Burnbank Medical Centre – New Patient Questionnaire

Name:	Telephone Number:
Address:	Mobile Number:
	Occupation:
Date of Birth:	Marital Status:
	Nationality:

Do you suffer from any of the undernoted conditions either now or in the past?

Conditions	State yes or no	If yes, please give details of nature of illness, date and any other information including doctors or hospitals concerned
Asthma, Bronchitis, Tuberculosis or other lung condition		
Heart Disease or abnormality, chest pain, high blood pressure or circulatory disease		
Persistent indigestion, duodenal ulcer, colitis or other disease of the stomach or intestine		
Urinary infection, kidney stones, disease of bladder, kidneys or any other abnormality discovered in urine		
Rheumatic fever, gout, arthritic disease or other disorder of bones, joints or muscles		
Diabetes or thyroid disorder		
Fainting, fits or epilepsy, paralysis or other disease of the central nervous system		
Anxiety depression or nervous breakdown		
Drug or alcohol problems		
Operation of any kind		
Any other disease, disability or serious injury		
Any known Allergies		
Have you ever had any gynaecological complaint or complication of pregnancy?		

P.T.O.

Family History

Please give details of the state of health or cause of death of your immediate family. State if any have ever had Heart Disease, Stroke, Diabetes, Asthma or a hereditary condition:-

Alive/Dead	Age Now	Or Age at Death	Cause of Death or state of health
Father			
Mother			
Sisters			
Brothers			

Lifestyle

How much alcohol do you take? (please give details of average weekly intake)	
How much do you smoke each day?	
Do you have a healthy diet?	
How much exercise do you take in a week?	

Females Only

Are you pregnant at present?	
Cervical Smear (Please state date of last test)	
Are you taking Hormone Replacement Therapy	
Are you taking the contraceptive pill and which make is it?	

Medication – THIS SECTION MUST BE COMPLETED

Name of Drug	Dosage

Last Tetanus Vaccine	Date:

I CERTIFY THAT THE ABOVE PARTICULARS ARE CORRECT

Signature:	Date:

FOR OFFICIAL USE ONLY:-

Height	Weight
Urinalysis	Blood Pressure:
Comments	Smoking Advice Given (if applicable) YES
Signature	Date