

MEDICAL QUESTIONNAIRE

Surname: (Mr / Mrs / Miss) **Date of Birth**

Forename: **Nationality:**

Address **Tel No:**

Occupation:

Marital status: Single / Married / Divorced / Widowed / Separated

NEXT OF KIN Name **Tel No:**

Relationship

PAST MEDICAL HISTORY

1. Please list in date order all important illness, including asthma, diabetes and heart disease or special investigations and operations.

Date

Details and Place

2. Are you at present suffering from any illness? Please list below

MEDICATION -

Please give details of drugs including dosages & frequency. These should be medicines you take regularly & anything you may purchase at the pharmacy. If available please provide a copy of the re-order list from your previous practice.

<u>NAME</u>	<u>DOSE</u>	<u>INSTRUCTIONS</u>
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Copy of repeat medication list received YES NO

3. Are you a carer? YES NO

Do you require the help of a carer? YES NO

4. Do you smoke? YES NO

If YES, how many? -----

Would you like help to stop smoking? YES NO

Do you drink alcohol? YES NO

If YES, how many units per week -----

5. Please list any substances, including medicines and drugs, to which you are allergic:

6. Immunisations:

Are you currently protected against:	Tetanus	YES	NO
	Polio	YES	NO
	Rubella	YES	NO
	Other	-----	

7. Do you have any family history of the following?

Heart Disease	YES	NO
Thyroid Disease	YES	NO
Diabetes	YES	NO
Asthma / eczema	YES	NO
Other:	-----	

8. FEMALES ONLY –

Have you had a cervical smear?	YES	NO
If YES, what was the date of your most recent?	-----	
How many pregnancies have you had?	-----	
How many have resulted in live births?	-----	
Are you taking oral contraceptives?	YES	NO
Do you have an IUCD fitted?	YES	NO
Do you have an Implanon fitted?	YES	NO