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
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2. **Are you at present suffering from any illness or receiving treatment or medicines?** **YES** **NO**

   If YES, please give details including drugs and dosages. Please include medicines you take regularly that are not prescribed by a doctor.

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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? ----------

   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:

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6. Immunisations:

Are you currently protected against:

Tetanus	**YES**	**NO**
Polio	**YES**	**NO**
Rubella	**YES**	**NO**
Other	----------	

7. Children under 5 - Please list all immunisations and dates.

8. 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: ----------

9. 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 and IUCD fitted?	**YES**	**NO**