…..Confidential…..Confidential…..Confidential…..Confidential…..

PATIENT QUESTIONNAIRE

This questionnaire has been designed to help your doctor with your medical problems if there are any questions that you are doubtful about or would rather not answer, please leave blank

Date today_____

Name: Mr/Mrs/Miss/Ms _____ D.O.B: _____

Maiden Name - if married: _____

If name not changed upon marriage please state: _____

Address: _____ Post Code: _____

Contact No: _____ Work: _____

Your E-Mail address _____

Person to contact in an emergency: Name: _____

Address: _____

Post Code: _____ Phone: _____

PERSONAL HISTORY;

Country of Birth: _____ **District if UK:(eg Ealing etc)** _____

Nationality: _____ (Please do not put London)

First Language: _____ Religion: _____

IF FROM ABROAD PLEASE STATE DATE OF ENTRY TO UK: _____

Please note this also includes - Scotland & Northern Ireland:

What is your occupation: _____

Are you: (circle) Black White Asian Other(specify) _____

Are you: (circle) Single Married Separated Divorced Remarried

If Widowed - in what year, please _____

How many siblings do you have: Brothers: Sisters:

How many children do you have? Please name with DOB

1 2

3 4

Do you keep any pets and if so what: _____

Do you provide routine care for someone? Y / N

Does someone provide care for you? Y / N If yes please add carer details below

Name and contact details of carer:

MEDICAL HISTORY:

Please list any medicines or tablets that you take, e either under medical supervision or of your own accord.

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

If you smoke cigarettes, cigars or tobacco - how many per day: _____

How many units of alcohol or beer do you drink per week _____

Date of last tetanus immunisation _____

Date of last Polio immunisation _____

Are you allergic to anything if Yes state what _____

What illness or operations have you had in the past:

Year _____

Year _____

Year _____

FAMILY HISTORY: If there is any serious physical or mental history in the family please state: _____

_____

If either parent has passed away, please state cause and age of death

Father _____

Mother _____

WOMEN ONLY

If you have had a miscarriage how many: _____ Terminations how many: _____

What contraception do you use: _____

If you use the pill, please state brand and how long you have used it: _____

When did you last have a cervical smear test: _____

Was the result: **Normal** or **Abnormal** **Never had a Smear** _____

Have you been immunised against Rubella (German Measles) Yes/No Date: _____

If relevant, year of onset of menopause: _____

Have you had a mammogram: Yes No

If yes please state date and where _____

NURSE USE ONLY:

Height: **Weight:** **BP:** **Urine:** **Date:**