

BIRKENHEAD MEDICAL CENTRE

New Patient Medical Questionnaire

Please complete one form for each member of your family and hand back to reception

Name: _____ DOB: _____ / _____ / _____

1. Do you have any, or have had any of the following medical problems?, or is there a family history of the following:

	Self	Family	Side of Family			Self	Family	Side of Family	
			Mother	Father				Mother	Father
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes			Blood clot	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes			Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
Heart disease or problems	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes			High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
Heart Attack <60yr >60yr	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes			Cancer Type:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes			Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes		

Any additional comments for items ticked "yes" above: _____

1. Please list any regular medications that you take:

2. Are you **allergic** to any medications? No Yes *If yes, please list*

3. Alcohol Consumption

- Non drinker
- Within Guideline
- Above Guideline

Guideline

- No more than 10 standard drinks per week
- At least two alcohol free days
- Not binge drinking (5 or more on one occasion)

4. Are childhood immunisations up to date? No Yes Don't know

Women: (those over 20 years & sexually active)

I. When was your most recent cervical smear? _____ Where: _____
e.g (specialist, overseas, family planning)

II. Have you ever had an abnormal smear? No Yes Don't know

III. Have you had a mammogram (those over 40 years)? No Yes If Yes, when? _____

Signed: _____

Date: _____

Measurements (To be completed by Nurse or GP)

Height _____ BP _____

WC _____ Weight _____

Completed by: _____

Date: _____