BIRKENHEAD MEDICAL CENTRE
New Patient Medical Questionnaire

Please complete one form for <u>each member</u> 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	☐ Yes	☐ Yes			Blood clot	☐ Yes	☐ Yes		
High blood pressure	☐ Yes	☐ Yes			Stroke	☐ Yes	☐ Yes		
Heart disease or problems	☐ Yes	☐ Yes			High cholesterol	☐ Yes	☐ Yes		
Heart Attack <60yr >60yr	☐ Yes	☐ Yes			Cancer Type:	☐ Yes	☐ Yes		
Asthma	☐ Yes	☐ Yes			Epilepsy	☐ Yes	☐ 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

☐ No**n drinker**
☐ **Within Guideline**
☐ **Above Guideline**

<u>Guideline</u>
- 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

<u>Women:</u> (*those over 20 years & sexually active)*

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

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: