New Patient Questionnaire

Please complete this form and return it to us.

Please provide all details of your vaccination history. Parents/Guardians, please provide a copy of this for children under 16 years old.

All the information you give us will be treated confidentially.

Personal Details					
Surname:		**Address:**			
First name:					
D.O.B.					
Tel Number:		**Postcode:**			
Mobile:		**Email:**			
Nationality:		**First language:**		**Country of birth:**	

Health Details			
Height:		**Weight, if known:**	
Do you smoke?		**If yes, how many per day?**	
Are you an ex-smoker?		**Weekly alcohol intake:**	

Medical History – tick as appropriate				
Do you suffer from any of the following:	Diabetes?		High blood pressure?	
	Heart disease?		Stroke?	
	Asthma?		Mental illness?	
	COPD?		Cancer?	
	Thyroid disease?		Osteoporosis?	
	Other serious illness?		If yes, please specify:	
If you have any known allergies, please state them here:				
Do you suffer from epilepsy?		**If yes, have you had a fit in the past 12 months?**		

Repeat Medication			
Are you on any repeat medications?		**If yes, do you have a repeat prescription slip from your previous GP?**	
If you have a slip, please provide us with it so we can record them. Otherwise, please list any medication you are currently taking below. We may need to contact your previous GP to confirm medication.			

Name of medication:	**Strength:**	**Reason for using drug:**

Females Only			
Have you had a hysterectomy?		**If no, date of last cervical smear:**	
Are you pregnant?		**If yes, how many weeks?**	