New Patient Questionnaire

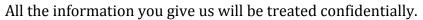
Please complete this form and return it to us.

Please provide all details of your vaccination history.

Parents/Guardians, please provide a copy of this for children

under 16 years old.

Personal Details





Surname:				Address:						
First name:										
D.O.B.										
Tel Number:				Postcode:						
Mobile:				Email:						
Nationality:			st language:	Country of birth:						
·		·								
Health Details										
Height:				Weight, if known:						
Do you smoke?	o you smoke?			If yes, how many per day?						
Are you an ex-smo	you an ex-smoker?			Weekly alcohol intake:						
					·					
Medical History –	tick as appr	opriate	2							
Do you suffer from Diabetes?		tes?			High blood					
any of the following	ng:				pressure?					
		leart lisease?			Stroke?					
A		Asthma?		Mental illness?						
COP		OPD?			Cancer?					
Thyro diseas					Osteoporosis?					
	Other seriou illness	ıs			If yes, please specify:					
If you have any known allergies, please state them here:		es,								
Do you suffer from epilepsy?				If yes, have the past 12	you had a fit in 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:	Streng	gth:	Reason for using drug:					
	<u>.</u>							

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