Greenhithe 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:** ____/____/____

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

	Self	Family		Self	Family
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	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

1. Do you have any other **health, disability problems or inherited conditions**? – *please list:*

2. Please list any **regular medications** that you take:

3. Have you had any **operations?** ☐ Yes ☐ No *If **yes**, please list:*

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

5. Do you **smoke/vape?** ☐ No
   ☐ Yes If yes, how many / day _____

   If Yes - would you like help to **quit smoking** ☐ Yes ☐ No

   Have you **ever smoked/vaped**? ☐ No
   ☐ Yes If yes, how much and for how long? _____
   When did you give up? _____

6. Do you drink **alcohol?** ☐ No
   ☐ Yes If yes, on average, how much / week? _____
   and what type? _____

7. Do you have any **substance abuse** problems? ☐ No ☐ Yes

8. When was your last Tetanus booster? _____

9. Are your childhood immunisations up to date? ☐ Yes ☐ No ☐ Don't know

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

10. When was your most recent cervical smear? _____
11. Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know
12. Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when?_____

Signed:_____ Date:_____