NEW PATIENT QUESTIONNAIRE

NAME DOB/CHI

ADDRESS TELEPHONE NUMBER

 MOBILE NUMBER

 POST CODE

OCCUPATION MARITAL STATUS

EMAIL

NEXT OF KIN RELATIONSHIP

ADDRESS OF NEXT OF KIN..........................................................................................................................

 POSTCODE

TELEPHONE NUMBER MOBILE NUMBER

**PLEASE COMPLETE THE FOLLOWING SECTIONS.**

|  |  |  |
| --- | --- | --- |
| **BLOOD PRESSURE** | **1ST READING** | **2ND READING** |
|  |  |
| **HEIGHT** |  |
| **WEIGHT** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Smoking status –**(if ex-smoker, please state when stopped and how many smoked) | **SMOKER** | **NEVER SMOKED** | **EX-SMOKER** |
|  |  |  |
| **Alcohol intake** (per Week) |  |

**Current Health**

**DO YOU OR ANY CLOSE FAMILY RELATIVE (i.e. mother, father, sibling) SUFFER FROM ANY OF THE FOLLOWING?**

|  |  |  |
| --- | --- | --- |
|  | **SELF** | **FAMILY RELATIVE** (please state relation and age, i.e. mother, father, sibling) |
| **HEART ATTACK** |  |  |
| **ANGINA** |  |  |
| **HEART SURGERY** |  |  |
| **DIABETES** |  |  |
| **STROKE** |  |  |
| **ASTHMA** |  |  |
| **THYROID PROBLEMS** |  |  |
| **EPILEPSY** |  |  |
| **HIGH BLOOD PRESSURE** |  |  |
| **LUNG / BOWEL / BREAST / PROSTATE CANCER** |  |  |
| **DEPRESSION** |  |  |
| **RHEUMATOID ARTHRITIS** |  |  |
| **HIGH CHOLESTEROL** |  |  |
| **OTHER SERIOUS ILLNESS OR OPERATIONS** |  |  |
| **Do you have any allergies?** |  |
| **List present medication and doses** |  |
|  |
| **Are you a carer?****If so how much of your day or week does this affect?** |  |
| **Do you exercise?****If so what do you enjoy on a regular basis?** |  |
| **Your Health is important to us:****Are there issues about your own or your family’s health that concern you?** |  |

**Thank you for taking the time to complete this questionnaire**