New Patient Medical Questionnaire

This form is required to complete your enrolment

Do you have any allergies? (food or medication) ◯ Yes ◯ No

Please state: ______________________________

Have you had any operations? ◯ Yes ◯ No

Please state when and why:

____

Please list any regular medications that you take:

____

Smoking status: ______________________________

When did you stop smoking? ______________________________

How many cigarettes per day did you smoke? ______________________________

How many cigarettes per day do you smoke? ______________________________

Do you vape: ◯ Yes ◯ No

Do you drink alcohol: ◯ Yes ◯ No **On average, how much per week:** ______________________________ **What type:** ______________________________

Do you have, or have you had, any of the following medical problems?

Or is there a family history of the following?

	Self	Family		Self	Family
Diabetes			Blood clot		
High blood pressure			Stroke		
Heart disease or problems			High cholesterol		
Heart attack			Migraine		
Asthma			Epilepsy		
Other lung or respiratory disease or problem			Breast cancer		
Kidney disease or problem			Other cancer		
Liver disease or Hepatitis			Glaucoma		
Bowel disease or problems			Rheumatic fever		
Joint disease or problems			Tuberculosis (TB)		
Depression and/or anxiety			Eczema		
Other mental health illnesses			Hay fever		

What is your weight:

____

What is your height:

____

When was your last Tetanus booster:

____

Are your childhood immunisations up to date:

- ○ Yes
- ○ No
- ○ Don't Know

When was your most recent cervical screening (if applicable):

Where was this taken:

Have you ever had an abnormal cervical screening:

- ◯ Yes
- ◯ No
- ◯ Don't Know
- ◯ Not Applicable

Have you had a mammogram (if applicable):

◯ Yes ◯ No

When:

ALL THE INFORMATION GIVEN IS TRUE TO MY KNOWLEDGE AND I ACCEPT THE TERMS OF PAYMENT

Signature of patient (or parent or guardian):

Signee:

Date: