**NEW PATIENT HEALTH QUESTIONNAIRE**

 **KEMNAY MEDICAL GROUP**

NAME: ...................................................................... DATE OF BIRTH: ............................

HOME TELEPHONE: .................................................. MOBILE: ........................................

ADDRESS: ...........................................................................................................................

.............................................................................................................................................

OCCUPATION: ....................................................................................................................

**HAVE YOU BEEN REGISTERED AT KEMNAY MEDICAL GROUP BEFORE? Yes/No (please circle)**

**ARE YOU A CARER? Yes/No (please circle) WHO ARE YOU CARING FOR?** ..................................

NEXT OF KIN

Name: ............................................................. Relationship to you: ...............................

Address/Number: ...............................................................................................................

LIFESTYLE

Height ............................................................... Weight....................................................

Never Smoked Current Smoker Ex-Smoker

How many units of Alcohol do you drink on average in a typical week? ...........................

(one unit = standard glass of wine, one pub measure of spirits or half a pint of beer)

Have you stopped drinking alcohol? Yes/No

If Yes, what year did you stop? ...................

MEDICATION/ALLERGIES

If you are currently on repeat prescriptions, please hand in your previous repeat form.

Are you allergic to any medications (please list) .............................................................................................................................................

BRIEF HISTORY OF CURRENT/PREVIOUS ILLNESSES, OPERATIONS, ACCIDENTS, ETC

Year

................. ..........................................................................................................................

................. ..........................................................................................................................

................. ..........................................................................................................................

................. ..........................................................................................................................

................. ..........................................................................................................................

FAMILY HISTORY

Have any of your immediate family (parents, brothers, sisters) had any of the following conditions?

|  |  |  |
| --- | --- | --- |
| Bowel Cancer  |  Breast Cancer  | Ovarian Cancer  |

Heart Disease/Stroke/Angina – before the age of 60 Osteoporosis

 FEMALES ONLY

Date of last smear .....................................................................................................................

Was this result Normal? Yes/No

If you have a coil fitted, when was it fitted? ................ Type of Coil (if known) .................. Do you have a contraceptive Implant? Yes/No When was this fitted? ...................

SURGERY USE ONLY

|  |  |
| --- | --- |
| Smoking  | Alcohol  |
| Height  | Weight  |
| Allergies  | Medical History  |
| Smear  | Immunisations  |