THE ORCHARD PRACTICE
New Patient Questionnaire

Personal Details

Surname
First Names
Address

Postcode

Title
Date of Birth
Marital Status
Occupation
Ethnic Origin
Place of Birth

Telephone numbers:
Home Mobile Work
E-mail Address:

Personal Medical History

Have you had any of the following? Please tick

☐ Hay Fever ☐ Asthma ☐ Angina ☐ High Blood Pressure
☐ Diabetes ☐ Heart Attack ☐ Glaucoma

Please list any other major illnesses or operations: ☐ None

Are you taking any medication? (including contraception) ☐ Yes (please list) ☐ No

1 2 3 4

5 6 7 8

Have you ever smoked? Yes / No When did you stop?
Do you smoke now? Yes / No How many per day?
Do you drink alcohol Yes / No How many units a week?
How much do you weigh?
How tall are you?

Do you have any allergies - medicines, drugs or dressings? ☐ Yes (please list) ☐ No
If so, what are you allergic to?

Family Medical History

Have any of you family (parents, brothers / sisters) ever had any of the following? (Please tick and state relation)

☐ Cancer If yes, what type of cancer? _____
☐ Asthma ☐ Glaucoma ☐ High Blood Pressure
☐ Diabetes ☐ Stroke ☐ Heart Attack/Angina before the age of 60

Children under 6:

Please complete dates for <u>all</u> vaccinations below

1st Dip/Tet/Pert/Hib/Polio
1st Pneumococcal
2nd Dip/Tet/Pert/Hib/Polio
1st Meningitis C
3rd Dip/Tet/Pert/Hib/Polio
2nd Meningitis C
2nd Pneumococcal
Hib/Men C Booster
1st MMR + Pneumococcal
2nd MMR
Pre-school Booster

Women Only

What was the date of your last smear?

Result:

Where was this taken?