GP CENTRAL

New Patient
Medical Questionnaire

Complete one form for each member of your family and return the papers to reception

Name: _____ **Occupation:** _____

Do you or your family have a history of any of the following medical problems?

	Self	Family		Self	Family
Diabetes	Yes ☐	Yes ☐	Blood clot	Yes ☐	Yes ☐
High blood pressure	Yes ☐	Yes ☐	Stroke	Yes ☐	Yes ☐
Heart problems	Yes ☐	Yes ☐	High cholesterol	Yes ☐	Yes ☐
Heart attack	Yes ☐	Yes ☐	Migraine	Yes ☐	Yes ☐
Asthma	Yes ☐	Yes ☐	Epilepsy	Yes ☐	Yes ☐
Lung/Respiratory disease	Yes ☐	Yes ☐	Breast cancer	Yes ☐	Yes ☐
Kidney disease	Yes ☐	Yes ☐	Other cancer	Yes ☐	Yes ☐
Liver disease or Hepatitis	Yes ☐	Yes ☐	Glaucoma	Yes ☐	Yes ☐
Bowel disease	Yes ☐	Yes ☐	Rheumatic Fever	Yes ☐	Yes ☐
Joint problems or Arthritis	Yes ☐	Yes ☐	Tuberculosis (TB)	Yes ☐	Yes ☐
Depression or Anxiety	Yes ☐	Yes ☐	Eczema	Yes ☐	Yes ☐
Other mental illness	Yes ☐	Yes ☐	Hay Fever	Yes ☐	Yes ☐

Do you have any other health, disability problems or inherited conditions?

Please list: _____

_____

Do you take any regular medications?

Please list: _____

_____

please turn over

Have you had any operations? No ☐ Yes ☐

Please list: _____

_____

Are you allergic to any medications? No ☐ Yes ☐

Please list: _____

_____

Do you vape? No ☐ Yes ☐

Do you smoke? No ☐ Yes ☐
How many per day: _____

Have you ever smoked? No ☐ Yes ☐
How much and for how long and when did you stop

_____

Do you drink alcohol? No ☐ Yes ☐
On average, how much per week , and what type

_____

Do you have any substance abuse problems? No ☐ Yes ☐

Are your childhood immunisations up to date? No ☐ Yes ☐ Don't know ☐
(please bring in your child's vaccination records)

When was your last Tetanus booster? _____

Women:

When was your most recent cervical screening?
(those over age 25) - smear or HPV swab? _____

Have you ever had an abnormal result? No ☐ Yes ☐ Don't know ☐

Have you had a mammogram? No ☐ Yes ☐ Don't know ☐
(those over age 40)- if yes, when?

Signed: **Date:**