St Heliers Health Centre **New Patient Medical Questionnaire**

Please complete one form for <u>each member</u> of your family and hand back to reception

Name: **<u>Occupation:</u>**

1. Do you have any, or have had any of the following medical problems?, or is there a family history of the following:

	Self	Family		Self	Family
Diabetes (#1434)	□ Yes	□ Yes	Blood clot (#12C9)	□ Yes	□ Yes
High blood pressure (#G2)	□ Yes	□ Yes	Stroke (#12C4)	□ Yes	□ Yes
Heart disease or problems (#14A)	□ Yes	□ Yes	High cholesterol (#1442)	□ Yes	□ Yes
Heart Attack <60yr (#12C2) >60yr (#12C3)	□ Yes	□ Yes	Migraine (#1474)	□ Yes	□ Yes
Asthma (#14B4)	□ Yes	□ Yes	Epilepsy (#1473)	□ Yes	□ Yes
Other lung or respiratory disease or problems	□ Yes	□ Yes	Breast cancer (#1243)	□ Yes	□ Yes
Kidney disease or problems	□ Yes	□ Yes	Other cancer (#124)	□ Yes	□ Yes
Liver disease or Hepatitis (#A70)	□ Yes	□ Yes	Glaucoma (#1482)	□ Yes	□ Yes
Bowel disease or problems	□ Yes	□ Yes	Rheumatic Fever (#G0)	□ Yes	□ Yes
Joint disease or problems, arthritis	□ Yes	□ Yes	Tuberculosis (TB) (#A1)	□ Yes	□ Yes
Depression and/or anxiety (#1465)	□ Yes	□ Yes	Eczema (14F1)	□ Yes	□ Yes
Other mental health illnesses (#EUZ)	□ Yes	□ Yes	Hay Fever (14B1)	□ Yes	□ Yes

2. Do you have any **other health, disability problems or inherited conditions**? – *please list*

3. Please list any **regular medications** that you take

4. Have you had any **operations?** □ Yes □ No *If **yes**, please list*

5. Are you **allergic** to any medications? □ Yes □ No *If **yes**, please list*

6. a) Do you **smoke?** □ No □ Yes If yes, how many / day

b) Have you ever smoked □ No □ Yes If yes, how much and for how long when did you give up

7. a) Do you drink **alcohol?** □ No □ Yes If yes, on average , how much / week and what type

8. Do you have any **substance abuse** problems? □ Yes □ No

9. <u>Women:</u> (*those over 20 years & sexually active)*

When was your most recent cervical smear?

Have you ever had an abnormal smear? □ Yes □ No □ Don't know

Have you had a mammogram (*those over 40 years*)? □ No □ Yes If Yes, when?

10. When was your last **Tetanus booster**?

11. Are your **childhood immunisations** up to date? □ Yes □ No □ Don't know
(please bring in your child's vaccination record for us to update our records)

Signed: Date:

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this.

Please be careful to disclose all important medical/surgical/psychiatric information.