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Medical Questionnaire

PATIENT INFORMATION	
Name:	
Occupation:	
Date of birth:	

PERSONAL INFORMATION			
Current medical problems:			
Current medication(s):			
Allergies to medication:			
Smoking history:	□ Never smoked	□ Current smoker	□ Ex-smoker
Smoking history (if relevant):	Year started:_____	Year stopped:_____	No. per day:_____
Alcohol (what and how much you drink in a week):			

MEDICAL HISTORY	
□ Respiratory disease: (type) _____	□ Heart disease/Stroke: (when) _____
□ Diabetes: (type) _____	□ High cholesterol/Raised blood pressure
□ Cancer: (type) _____	□ Liver disease: (type) _____
□ Kidney disease: (type) _____	□ Operations: (please list) _____
□ Other: (please list) _____	_____
_____	_____

FAMILY HISTORY (has anyone in your family had any of these? If so, write their relationship to you and when they were diagnosed)	
□ Respiratory disease: (type/who) _____	□ High cholesterol/Raised blood pressure: (who)
□ Diabetes: (type/who) _____	_____
□ Cancer: (type/who) _____	□ Liver disease: (type) _____
□ Kidney disease: (type/who) _____	□ Other: (please list) _____
□ Heart disease/Stroke: (when/who) _____	_____
	_____

SCREENING AND IMMUNISATIONS			
Cervical screening:	□ Yes, had one (when)_____	□ Never had one	□ I have had past abnormal smears
Mammogram:	□ Yes, had one (when)_____	□ Never had one	
Childhood immunisations:	□ Yes, I am up to date	□ I have had some	□ Never had any
Tetanus:	□ Yes (when)_____	□ Never had one	