New Patient Medical Questionnaire

health-i care

Please complete this form with your Patient Registration for each member of your family, and hand back to reception. This information is for your medical record only. It relates to your heath and any health screening which may be recommended for you.

Name_____ **Date of birth**_____

1. **Do you have any (or have had any) of the following medical problems? Is there a family history of the following? Please tick circles:**

	Self	Family		Self	Family
Diabetes	O Yes	O Yes	Blood clot	O Yes	O Yes
High blood pressure	O Yes	O Yes	Stroke	O Yes	O Yes
Heart disease or problems	O Yes	O Yes	High cholesterol	O Yes	O Yes
Heart Attack <60yr >60yr	O Yes	O Yes	Migraine	O Yes	O Yes
Asthma	O Yes	O Yes	Epilepsy	O Yes	O Yes
Other lung or respiratory disease or problems	O Yes	O Yes	Breast cancer	O Yes	O Yes
Kidney disease or problems	O Yes	O Yes	Other cancer	O Yes	O Yes
Liver disease or Hepatitis	O Yes	O Yes	Glaucoma	O Yes	O Yes
Bowel disease or problems	O Yes	O Yes	Rheumatic Fever	O Yes	O Yes
Joint disease or problems, arthritis	O Yes	O Yes	Tuberculosis (TB)	O Yes	O Yes
Depression and/or anxiety	O Yes	O Yes	Eczema	O Yes	O Yes
Other mental health illnesses	O Yes	O Yes	Hay Fever	O Yes	O 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. **Are you allergic to any medications? Please list here**:_____
5. **Have you had any operations? Please list:**_____
6. **Do you smoke?**
   - ☐ **Yes, I smoke** (quantity)_____. **I would like help to quit smoking:** ☐ **Yes** ☐ **No**
   - ☐ **Ex-smoker. I quit smoking in** (year)_____
   - ☐ **Never smoked.**
7. **Do you drink alcohol?**
   - ☐ **Yes, on average I drink** (quantity)_____ **a week. Alcohol types**_____
   - ☐ **No, I don't drink alcohol.**
8. **Do you have any substance abuse problems?** ☐ **Yes** ☐ **No**
9. **For women (age 25 or older)**
   a) **When was your most recent cervical smear?** (year)_____
   b) **Have you ever had an abnormal smear?** ☐ **Yes** ☐ **No**
   c) **Have you had a mammogram (age 45 or older)?** ☐ **Yes** ☐ **No**
10. **When was your last Tetanus booster? Year**_____ **or** ☐ **I don't know**
11. **Are your childhood immunisations up to date?** ☐ **Yes** **or** ☐ **I don't know**
12. **Do you have other family members registered at Health-I Care? Please write their names:**

    _____

Signature_____ **Date**_____

☐ File to patient notes ☐ Link family files