FEMALE

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Tel. Appointments & Queries 01769 580269

Patient Questionnaire

PERSONAL INFORMATION

Name (Mr / Mrs / Miss / Ms):………………………………………………………

Address: …………………………… Date of Birth: ………………………..

………………………………………. Weight: ………………………………

……………………………………….. Height: ………………………………...

……………………………………….. Waist measurement………………….

Current Smoker? YES / NO

Post Code: ………………………… If yes how many a day? …………….

Tel No: ……………………………… Used to Smoke? YES / NO

Do you drink alcohol? YES / NO

(A unit of alcohol is half a pint of beer, a glass of wine or standard pub measure of spirits).

How many units per week? ……………………………………………………………

How would you describe your diet as? ……………………………………………

How much exercise do you take? None / 1x week / 2x week / more often

Form of exercise e.g. Swimming / Walking? ………………………………………

Do you normally have a Flu Vaccination? YES / NO

Have you ever had a vaccination against pneumonia? YES / NO

(If yes when did you have it? ………………………)

Have you ever had a Heart Attack or suffer from Chest Pains? ………………………

Have you ever had Heart Surgery? YES / NO (If yes when? ……………………

Have any members of your family suffered from any of the following:

Condition / Illness	Member of family
Heart Attack < 60	
Heart Attack > 60	
Angina < 60	
Angina > 60	
Stroke	
Diabetes	
Asthma	

Please continue overleaf.

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Have you got any medical conditions e.g., Diabetes, Asthma, Blood Pressure, Eye Problems.

Please list: 1) …………………………………

2) …………………………………

3) …………………………………

4) …………………………………

Have you had any operations? Please list.

1) ………………………………….

2) …………………………………..

3) …………………………………..

4) ……………………………………..

Do you have any allergies? YES / NO

(If yes please describe ……………………………………………………………)

Do you currently have any ongoing blood tests or investigations? YES / NO

(If yes please give details ………………………………………………………..)

Please list below any immunisations you know or have records for:

Immunisation:	Date:

When did you last have a Cervical Smear? (Date)……………………………….

Do you examine your Breasts regularly? YES / NO

Date: ……………………………………. Signature: ……………………………

If you take any medication please make an appt to see a doctor.