

MALE

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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?

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 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	

MALE

Please continue overleaf.

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

- Please list: 1)
2)
3)
4)
5)
6)

Have you had any operations? Please list.

- 1)
2)
3)
4)
5)

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:

Do you examine your Testicles regularly? YES / NO

Date: Signature:

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