

Date:.....

GP's Name: .....

### The Studholme Medical Centre New Patient Questionnaire

Please take time to complete the questionnaire as fully as possible.

Surname: \_\_\_\_\_

Post Code: \_\_\_\_\_

Forename: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_

Spouses Occupation: \_\_\_\_\_

Ethnicity: (Please state)

NHS No. \_\_\_\_\_

British/ Mixed -----

Other white -----

Other Mixed -----

Other Asian -----

Other Black -----

Other -----

#### Personal Medical History:

Please specify any major illness or operations, with dates

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you suffered from:

Heart Disease/Heart Attack?	Y/N
Strokes	Y/N
Blood pressure?	Y/N
Diabetes	Y/N
Asthma	Y/N
Eczema/Hayfever?	Y/N
Epilepsy?	Y/N
Blindness/Glaucoma?	Y/N
Cancer?	Y/N
Depression/Psychosis?	Y/N

#### Family Medical History: Please specify age, any serious illness (If dead – age at death and cause)

Mother: \_\_\_\_\_

Have any of your parents, brothers or sisters suffered from:

Father: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Heart attack?	Y/N
Angina?	Y/N
Stroke?	Y/N
High blood pressure?	Y/N
Diabetes?	Y/N
Cancer?	Y/N
What type? _____	

#### Drugs and Medicines: Please specify all drugs, medicines, tablets or pills that you take regularly: (Please supply old repeat prescription slip if available)

Name:	Dose:
_____	_____
_____	_____
_____	_____

Are you allergic to any drugs or medicines

Y/N Which ones? \_\_\_\_\_

**YOUR HEALTH:**

Do you smoke? Y/N How many cigarettes/oz. tobacco? \_\_\_\_\_

***If you do smoke, please STOP as smoking will damage your health  
If you need help or advice to help stop smoking please see your GP  
NHS Smoking Helpline: 0800 1690169***

Do you drink alcohol ? Y/N How many units per week? \_\_\_\_\_ 1 unit = ½ pint of beer  
or 1 measure of spirits  
or 1 glass of wine

Do you take any regular exercise or sport? \_\_\_\_\_  
Please grade yourself on a scale of 1 to 10 – where 1 “avoid even trivial exercise”  
10 “competitive athlete”

Do you have a balanced diet? Y/N?

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**WOMEN: Please be as accurate as possible**

Have you had a cervical smear test in the last 3 years Y/N If yes: Date \_\_\_\_\_ Result \_\_\_\_\_

Was it carried out at your doctors surgery? Y/N If no: Where? \_\_\_\_\_

Have you had a hysterectomy? Y/N If yes: When? \_\_\_\_\_ Why? \_\_\_\_\_

Do you take the contraceptive pill? Y/N If yes: Which one? \_\_\_\_\_

Do you have a coil/IUD fitted? Y/N If yes: When fitted? \_\_\_\_\_  
What type of coil? \_\_\_\_\_

Are you pregnant? Y/N

Remember, this practice provides family planning and well woman screening. Smear tests are carried out by our nurses.

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**PLEASE MAKE AN APPOINTMENT FOR A NEW PATIENT CHECK WITH OUR NURSES . THANK YOU.**

Drs. Couch, Moore, Butt, Tang, McFarlane & Alvi