AVICENNA/OAKDALE MEDICAL CENTRE

NEW PATIENT QUESTIONNAIRE

Please hand this form into reception along with your registration form

SURNAME: ……..……

FORENAME(S): ……..……

DATE OF BIRTH: ……..

ADDRESS: ……..
……..
……..
……..
……..

TEL.NUMBER: ……..

NEXT OF KIN: Name ……..
Address ……..
……..
Tel No ……..…

What is your occupation? ……..

Are you taking any regular ……..
medication? ……..
If yes, please specify ……..
……..
……..

Do you or anyone in you family suffer from any of the following?

	Self	Family
Heart Disease	Yes/No	Yes/No relationship……..……
Stroke	Yes/No	Yes/No relationship…….……..
Diabetes	Yes/No	Yes/No relationship…….……..
High Blood Pressure	Yes/No	Yes/No relationship……...
Asthma	Yes/No	Yes/No relationship…….……..
Bronchitis/Emphysema	Yes/No	Yes/No relationship……...

Do you have any allergies? ……...…….....

Have you had any operations? ..……

Any major illnesses, apart from those above, have you suffered or are suffering from? ……..
……..
……..

Are you a smoker? Yes/No
If yes, how many? ……..
If ex-smoker when did you give up and how many per day? ……..
……..

How much alcohol do you consume per week? ……..
…….....

How much exercise do you take? ...……...

Are you on a special diet? ……..

What is your ethnic origin? White ….Black….Asian….Chinese….Mixed….
Other……...…..(tick as appropriate)

What is your first language? ……..

English speaking contact in case of an emergency ……..

FEMALES ONLY ANSWER THE FOLLOWING (if applicable):

When was your last cervical smear? ……..

When was your last breast screening?.....

Have you had a hysterectomy? ……..

Are you pregnant? ……..

What form of contraception are you using? ……..
……..