BRAIDS MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE

Please complete as fully as possible. Thank you in anticipation:

Full name: .....

Maiden name if applicable: .....

Address: .....

Telephone Number: .....

Date of birth: .....

Marital status: .....

Occupation: .....

Ethnic origin: .....

NHS number (found on medical card): .....

Please list below any major illnesses, operations or accidents that you have had in your lifetime with dates, and name of hospital if relevant. (Use extra space below if necessary!)

Date	Problem	Hospital

In particular, do you have, or have you ever had, any of the following. If so please circle:

Diabetes	Yes/No	Asthma	Yes/No
High blood pressure	Yes/No	Chronic bronchitis	Yes/No
Epilepsy	Yes/No	Arthritis	Yes/No
Heart disease	Yes/No	Depression	Yes/No

Have any of your family had any of the above ? If so please provide details:

Relative	Illness/Condition

Allergies .....

.....

Do you have any medication which has been prescribed by a doctor? Please list below with the name of drug and dosage.

Drug	Dose

Do you currently smoke? Yes / No

If yes how many?

Have you ever smoked regularly? Yes / No

Do you drink alcohol? Yes / No

If yes how many units per week? ..... (One unit = one glass of Wine, sherry, one measure of spirits or half a pint of beer)

Do you exercise regularly?

For women ONLY

Date of last cervical smear .....month.....year

Who was it it by (Delete as appropriate):
- GP
- Family Planning Clinic
- Hospital

Result:

If you have never had a smear would you like one? Yes/No

Number of children.....

Any problems during pregnancy or delivery ?