PATIENT QUESTIONNAIRE

This set of questions has been designed to help your new General Practitioner get to know you and your medical problems.

The information you provide will be handled confidentially by your doctor but if you are concerned about any questions please leave them blank. Your doctor will be pleased to clarify any points.

It will be appreciated if you can return the completed forms to the surgery as soon as possible or bring them with you when you first visit the doctor.

Mr./Mrs./Miss……...Date of birth…….

Address: ……

……..Tel.No……..

Date when Questionnaire completed……..

What is your nationality and country of birth……

If not of British origin – how long have you been in this country?
Years……..

What is your marital status –
Single/Married/Divorced/Separated/Remarried/Widowed (please circle)

If married, what year were you married?.....
If widowed, when did your spouse die?.....

Name & Address of previous doctor: Dr……
Address……...
……..

CHILDHOOD ILLNESSES

Please tick those illnesses which you have had and give approximate age if possible:-

MUMPS AGE	MEASLES AGE	DIPHTHERIA AGE	CHICKENPOX AGE	ASTHMA AGE
GERMAN MEASLES AGE	SCARLET FEVER AGE	RHEUMATIC FEVER AGE	CHILDHOOD ECZEMA AGE	WHOOPING COUGH AGE

ILLNESSES, ACCIDENTS OR OPERATIONS

Please list all SERIOUS ILLNESSES, ACCIDENTS, HOSPITAL ADMISSIONS or OPERATIONS with dates and details of hospital. Please also list any present illnesses which you have:

PRESENT MEDICINES
Please list any medicines or tablets you are taking at present, and the illness for which you are taking them.

ALLERGIES
Are you allergic or sensitive to any medicines, food, animals etc?

IMMUNISATIONS
Please tick if you have been immunised against the following illnesses, and if possible five the dates of last vaccinations.

		Date			Date			Date
Diptheria	☐		Measles	☐		Polio	☐	
Smallpox	☐		Tetanus	☐		Influenza	☐	
German Measles	☐		Tuberculosis	☐				
Typhoid Fever	☐		Whooping Cough	☐				

BLOOD

Do you know what your blood group is?.....

Have you ever been a blood donor?.....

Have you ever received a blood transfusion?.....

SMOKING & ALCOHOL

Do you smoke now?.....Cigarettes ……..Cigars……..Pipe…….

If you have now stopped smoking:-

When did you stop?.....What was the maximum smoked?……..

If you are still smoking:-

How much each day?.....How old were you when you started?.....

Have you tried to give up?.....Have you cut down recently? …….

What was the maximum number per day you have smoked?.....

How much alcohol do you drink per week?.....

WEIGHT

What is your weight now?.....

Would you say you are:- Slightly underweight ☐ Slightly overweight ☐ Just the right weight ☐
Very underweight ☐ Very overweight ☐

Have you lost any weight recently?.....Have you put any weight recently?.....

HEIGHT

What is your height……..

OCCUPATION

What is your occupation?.....

What does your job actually entail?.....

……...

What other jobs have you had in the past?.....

HOBBIES

Please list your hobbies, recreational and sporting activities

PETS

Please list any pets or animals which you keep

FAMILY HISTORY

Do you or any of your family or close relations have any of the following illnesses or conditions:-

	YES or NO	Please give details
Sugar Diabetes		
High Blood Pressure		
Heart Attack		
Stroke		
Epilepsy or Fits		
Asthma		
Skin Disease		
Nervous Disorders		
Allergies		
Congenital Diseases		
Cancer		
Kidney Disease		
Thyroid Disorder		
Twins		
Other Diseases		

Are your parents still alive and in good health?

Mother …… Father…….

(if either has died could you please say how old they were when they died and what was the known Cause of death).

Please list your *brothers and sisters* with their ages and give details of any serious illnesses they have suffered.

Is there any other information you may think helpful?

WOMEN ONLY

PERIODS

At what age did your periods start?.....

If you still have periods now please answer the following questions:-

Are your periods regular?.....

How many days in the cycle?.....

How long does the bleeding last?.....

Is the bleeding heavy?.....

How much pain do you get with your periods:-

Little……. Moderate…… A lot……

If your periods have finished when did they do so?

Do you use contraceptives: The Contraceptive Pill
Intra-uterine Coil
Diaphragm
Condom
Other Methods

If you use the Contraceptive Pill – for how long have you been taking it?.....

Do you get any side effects?.....

Have you had a cervical (cancer) smear?.....

What was the date of the last one?.....

CHILDREN

Please list all children that you have had:-

Name	Date of Birth	Difficulties with pregnancy or birth (and birth weight if known)

Have you had any miscarriages? – Please give details