

The Grove Medical Practice Medical questionnaire for new patients (1)

It may be some time before we receive your medical records and if you are have moved to the UK from abroad, we will not be have any historical medical records for you.

We would be grateful therefore if you could complete this form to help the doctors and nurses to provide you with proper care.

Name:

Sex: Male Female Date of Birth:

MEDICAL HISTORY

Please list any serious condition/illness/operation

Year	Condition
.....
.....
.....
.....
.....
.....

Have you ever had:

High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart Attack	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Date of Last Tetanus

Any Allergy Yes No

Please list All Your Medication

Name	Dose	How Often
.....
.....
.....

Do You Smoke? Yes No

Number of Cigs per day:

Do You Drink? Yes No

Pints per week:

Shots per week:

Glass of wine per week:.....

Do you take any form of regular exercise?

Do you need any alternative treatment as a result of your religion or culture? Yes No

If yes, please specify:

Women Only: What type of contraception are you using?

Date of Last Smear Result:

Date of Last Mammogram: Result:

FAMILY HISTORY

Has any of your family (mother/father, brother, sister, uncle, aunt) suffered from: (please tick)

High blood pressure Heart Attack

Diabetes Stroke

Asthma Epilepsy

Any other condition: