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

..... ……..
..... ……..
..... ……..
..... ……..
..... ……..
..... ……..

Date of Last Tetanus ……..

Please list All Your Medication

Name Dose How Often

…… …… ……
…… …… ……
…… …… ……

Do you take any form of regular exercise?

Have you ever had:

High blood pressure Yes ☐ No ☐
Asthma Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Heart Attack Yes ☐ No ☐
Stroke Yes ☐ No ☐
Glaucoma Yes ☐ No ☐

Any Allergy Yes ☐ No ☐

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 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: ……