Whitevale Medical Group

NEW PATIENT QUESTIONNAIRE

Name: _____ MALE / FEMALE

Date of Birth: _____ Occupation: _____

Address: _____

_____

Home Tel: _____ Mobile: _____

E-Mail Address:_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS: (PLEASE TICK)

High Blood Pressure	Stroke	Heart Condition	Asthma
Epilepsy	Diabetes	Thyroid	
Any other major illness:			

SMOKING: Tick only one box	NEVER SMOKED	SMOKER	EX-SMOKER

How many cigarettes do you smoke daily?

How many units of alcohol do you drink per week?

MEDICATION: Are you currently taking any medication? - Please list.	
ALLERGIES: Do you have any allergies? - Please list.	

ADULT FEMALE PATIENTS ONLY	Year of last Smear Test:
Cervical Smear Test:	Taken at GP/ Clinic / Abroad:
Hysterectomy: If you have had, please detail:	Result of Test:
	Never had a Smear Test: