

# Whitevale Medical Group

## NEW PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_ MALE / FEMALE

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Next of Kin-Name & Contact No: \_\_\_\_\_

### 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
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How many cigarettes do you smoke daily?
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How many units of alcohol do you drink per week?
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MEDICATION: Are you currently taking any medication? - Please list.	
ALLERGIES: Do you have any allergies? - Please list.	

### ADULT FEMALE PATIENTS ONLY

Cervical Smear Test:

Hysterectomy: If you have had, please detail:

Year of last Smear Test:

Taken at GP/ Clinic / Abroad:

Result of Test:

Never had a Smear Test: