**FINLAYSON STREET SURGERY – NEW PATIENT HEALTH QUESTIONNAIRE**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Have you or any members of your immediate family had any of the following illnesses?

Asthma You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

Chest Problems You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

Diabetes You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

Heart Problems You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

High Blood Pressure You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

High Cholesterol You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

Stroke You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

Thyroid Disease You: [ ]  Mother: [ ]  Father: [ ]  Sister: [ ]  Brother: [ ]

**Please list any other major illnesses or operations you have had:**

**MEDICATION**

Please list any medications you are prescribed regularly:

**ALLERGIES**

Please list any medicines you are allergic to:

**Tetanus Status:** When did you last have a tetanus vaccination? \_\_\_\_\_\_\_\_

**Smoking Status:** Smoker [ ]  Ex-smoker [ ]  Never smoked [ ]

**Alcohol Intake:** Current drinker [ ]  Units per week \_\_\_\_\_\_\_\_

 Lifelong teetotaller [ ]  Ex-drinker [ ]

**Exercise:** Most days [ ]  Once a week [ ]  3 times a week [ ]

 No form of regular exercise [ ]  Exercise physically impossible [ ]

**Women Only:** Have you had a hysterectomy? Yes [ ]  (Date \_\_\_\_\_\_\_\_) No [ ]

If no, please give the date of your last smear? \_\_\_\_\_\_\_\_

**Children Only:** Please provide a list of any childhood vaccinations