**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