

ST LUKE'S SURGERY
NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire.
It must be returned with your registration form
failure to do so may delay your registration

Name _____ Date of Birth _____

Address _____

Tel No. _____ Mobile No. _____

Ethnic Origin _____ Occupation _____

Height _____ Weight _____ Do you smoke? Yes/No/Ex Smoker

If you are under 16 do your parents smoke? Yes/No

How much alcohol do you drink a week? _____

Are you registered Disabled? Yes/No Are you housebound? Yes/No

Do you have a Carer? Yes/No Do you care for a family member? Yes/No

Medical History:

Are you suffering or have you ever suffered from any of the following?
(Please enter date diagnosed)

High Blood Pressure

Asthma

Diabetes

High Cholesterol

Stroke/Mini-stroke/TIA

Heart Disease

Angina or other

Epilepsy

Thyroid Disease

Depression

Learning Disabilities

If you have any of the above would you like to be invited to the appropriate clinics this year? Yes/No (please circle)

Family History: Do you have any family history of the above

or of any cancers _____

Please turn over

Allergies: Do you have any known allergies or adverse reactions to any medications?

Medication: Do you take any regular repeat medication?

Please list (continue on a new sheet if necessary)

Are you up to date with tetanus vaccine Yes/No Date last given _____

Signed _____ Date _____

FEMALE PATIENTS ONLY - aged 20 – 64 yrs

When was your last Cervical Smear? Date _____

Are you aware of the result? Yes/No If yes _____

If your smear test is due or you have never had a smear test do you wish to have one? Yes/No

Have you had a Hysterectomy? Yes/No

Date/Details _____

**IF YOU REQUIRE THIS FORM IN LARGER PRINT PLEASE
ASK AT RECEPTION**

All the information given will be treated confidentially