PICTON SURGERY

New Patient Medical Questionnaire

Name: **Date of birth:**

Medical conditions

Do you have or had any of the following medical conditions? Please include family history.

	Self	Family		Self	Family
Diabetes	◻ Yes	◻ Yes	Blood clot	◻ Yes	◻ Yes
High blood pressure	◻ Yes	◻ Yes	Stroke	◻ Yes	◻ Yes
Heart disease	◻ Yes	◻ Yes	High cholesterol	◻ Yes	◻ Yes
Heart attack – age?	◻ Yes	◻ Yes	Migraine	◻ Yes	◻ Yes
Asthma	◻ Yes	◻ Yes	Epilepsy	◻ Yes	◻ Yes
Lung disease	◻ Yes	◻ Yes	Cancer - breast	◻ Yes	◻ Yes
Respiratory disease	◻ Yes	◻ Yes	Cancer - other	◻ Yes	◻ Yes
Liver disease or Hepatitis	◻ Yes	◻ Yes	Glaucoma	◻ Yes	◻ Yes
Bowel disease or related	◻ Yes	◻ Yes	Rheumatic Fever	◻ Yes	◻ Yes
Joint disease, arthritis	◻ Yes	◻ Yes	Tuberculosis (TB)	◻ Yes	◻ Yes
Depression, anxiety,wellness or mental health conditions	◻ Yes	◻ Yes	Eczema	◻ Yes	◻ Yes
			Hay Fever	◻ Yes	◻ Yes
Any other conditions?	◻ Yes				

Medication, operations, alcohol and drugs: Please list if you have/or had:

Regular medications	◻ Yes	◻ No	
Allergic Reactions	◻ Yes	◻ No	
Operations	◻ Yes	◻ No	
Do you smoke?	◻ Yes	◻ No	How many each per day?
Do you drink alcohol?	◻ Yes	◻ No	What type & how many glasses each week?
Do you have substance abuse problems?	◻ Yes	◻ No	Substance type:

Immunisations & Vaccinations:

Childhood immunisations up-to-date?	◻ Yes	◻ No	
Tetanus booster ?	◻ Yes	◻ No	When?

Women: Have you had a:

Cervical smear 20yr olds+	◻ Yes	◻ No	Result: Abnormal? ◻ Yes ◻ No
Mammogram 40yr olds+	◻ Yes	◻ No	When?