NEW PATIENT QUESTIONNAIRE

SURNAME	
FORENAMES	
DATE OF BIRTH	
ADDRESS	
OCCUPATION	
TEL: (HOME)	
TEL: (MOBILE)	
EMAIL:	

PAST MEDICAL HISTORY (any diseases or operations with approximate dates)	
MEDICATION (including doses)	
ALLERGIES	

FAMILY HISTORY OF: Heart Disease, Diabetes, Cancer, Other (especially if younger than 60 years)	
Smoking (daily consumption)	
Alcohol (units per week)	
Exercise	
Contraception	
Last Smear	
Vegetarian (or other eating habit)	

FOR GP USE:

Height	
Weight	
BP	
Urine Test	