NEW PATIENT HEALTH QUESTIONNAIRE

Please complete this short questionnaire to help us update your records.

NAME: ..... **Date of Birth:** .....

Marital Status: ..... **Occupation:** .....

FAMILY HISTORY *(i.e. parents, brothers, sisters)* before age 65 ?

	YES	NO	Father	Mother	Brother	Sister	
Heart Attack?	☐	☐	☐	☐	☐	☐	
Stroke?	☐	☐	☐	☐	☐	☐	
High Blood Pressure?	☐	☐	☐	☐	☐	☐	
High Cholesterol?	☐	☐	☐	☐	☐	☐	
Diabetes?	☐	☐	☐	☐	☐	☐	
Asthma?	☐	☐	☐	☐	☐	☐	
Cancer?	☐	☐	☐	☐	☐	☐	*Specify site of Cancer:* _____

SMOKING: Do you smoke? Never Smoked ☐ Yes ☐ How many per day? .....

Ex Smoker ☐ When did you stop? .....

ALCOHOL: How many units of alcohol do you drink per week?
(1 unit = ½ pint beer, 1 glass wine or a pub measure of spirits) .....

EXERCISE: Do you exercise regularly? Yes ☐ No ☐ Which activity? .....

DIET: Do you have a healthy diet? Yes ☐ No ☐

CARERS: Are you a carer? Yes ☐ No ☐ If yes, who for? .....

May we pass your details to Angus Carers Centre for advice/support? Yes ☐ No ☐

Women date of: Last Cervical Smear ..... Result: Positive ☐ Negative ☐

Hysterectomy ..... Total / Other .....

Men : Do you regularly do a Testicular Self-Examination? Yes ☐ No ☐

Have you ever suffered from? (tick as appropriate and state year first diagnosed)

	YES	NO	Year Diagnosed		YES	NO	Year Diagnosed
Epilepsy	☐	☐		Cancer	☐	☐	
High Blood Pressure	☐	☐		Diabetes	☐	☐	
Heart Attack	☐	☐		Asthma	☐	☐	
Stroke	☐	☐		COPD	☐	☐	
Blindness/Glaucoma	☐	☐		Erectile Dysfunction	☐	☐	
Eczema	☐	☐		Hay Fever	☐	☐	
Anxiety	☐	☐		Depression	☐	☐	
OCD	☐	☐		Bipolar Disorder	☐	☐	

Other Health Problems:

	Medication	*Dosage*
Please list present MEDICATION & DOSES:		
Allergies / Sensitivities:		

Are you registered disabled? Yes ☐ No ☐ If yes, give details

Added to patient computer record ☐ *Date:* ..... *Initials:* .....