REDICARE FAMILY PRACTICE **New Patient Medical Questionnaire**

Please complete one form for **EACH MEMBER** of your family and hand back to reception

Name:_____ DOB: _____

1. Do you have any, or have had any of the following medical problem? or is there a family history of the following:

	Self	Family		Self	Family
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart Attack ☐ < 60yr ☐ > 60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

2. Do you have **any other health, disability problems or inherited conditions**? — please list

3. Please list any **regular medications** that you take

4. Are you **allergic** to any medications? ☐ Yes ☐ No *If Yes, please list,*

5. Have you had any **operations**? ☐ Yes ☐ No *If Yes, please list,*

6. Do you smoke? ☐ No ☐ Yes *If yes, how many / day* _____
   - If Yes - would you like help to **quit smoking** ☐ Yes ☐ No
   - Have you ever smoked ☐ No ☐ Yes
   - If yes, how much and for how long _____ When did you give up_____

7. Do you drink alcohol? ☐ No ☐ Yes

   If yes, on average, how much / week _____ What type _____

8. Do you have any **substance abuse** problems? ☐ No ☐ Yes

9. Women: *(those over 20 years & have ever been sexually active)*
   - When was your most recent cervical smear? _____
   - Have you ever had an abnormal smear? ☐ No ☐ Yes ☐ Don't Know
   - Have you had a mammogram (those over 40 years)? ☐ No ☐ Yes, If Yes, when? _____

10. When was your last **Tetanus booster**? _____

11. Are your childhood immunizations up to date? ☐ No ☐ Yes ☐ Don't Know

Signed: _____ Date: _____