

FEMALE

Stratton Medical Centre, Hospital Road, Stratton, Bude, Cornwall
Tel: 01288 352133

Patient Questionnaire

PERSONAL INFORMATION

Name (Mrs / Miss / Ms):.....

Address:..... Date of Birth:.....

..... Weight:.....

..... Height:.....

..... Waist Measurement:.....

Nationality Current Smoker? YES / NO

Post Code:..... If yes how many a day?.....

Tel No:..... Used to smoke? YES / NO

Do you drink alcohol? YES / NO When did you give up?

(A unit of alcohol is half a pint of beer, a glass of wine or standard pub measure of spirits).

How many units per week?.....

How would you describe your diet?.....

How much exercise do you take? None / 1x week / 2x week / more often

Form of exercise e.g. Swimming / Walking?.....

Do you normally have a Flu vaccination? YES / NO

Have you had a vaccination against Pneumonia? YES / NO

(If yes when did you have it?.....)

Have you ever had a Heart Attack or suffer from Chest Pains?.....

Have you ever had Heart Surgery? YES / NO (If yes when.....)

Are you a main carer for anybody? YES / NO (If yes who.....)

Have any members of your family suffered from any of the following:

Condition / Illness	Member of family
Heart Attack < 60	
Heart Attack > 60	
Angina < 60	
Angina > 60	
Stroke	
Diabetes	
Asthma	

Please continue overleaf

FEMALE

Have you got any medical conditions e.g., Diabetes, Asthma, Blood Pressure, Eye Problems?

Please list: 1).....
2).....
3).....
4).....
5).....
6).....

Have you had any operations? Please list.

1).....
2).....
3).....
4).....
5).....
6).....

Do you have any allergies? YES / NO

(If yes please describe.....)

If you take any medication please make an appointment to see a doctor.

Please list below any immunisations you know or records for:

Immunisation:	Date:

When did you last have a Cervical Smear? (Date):.....

Do you examine your Breasts regularly? YES / NO

Date:..... Signature:.....