

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

Female

Patient Questionnaire

PERSONAL INFORMATION

Name:- Mrs/Miss/Ms

Address:	Nationality:
	Date of Birth:
	Weight:
Post Code:	Height:
Tel No:	Waist Measurement:

Current Smoker?	YES / NO	If yes to either how many cigarettes/cigars a day or Pipe/Roll your own oz/wk?
Used to smoke?	YES / NO	
When did you give up?		

Do you drink alcohol? YES / NO	How many units per week?
(A unit of alcohol is half a pint of beer, a glass of wine or standard pub measure of spirits).	

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
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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

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 have records for.

Immunisation:

Date:

When did you last have a Cervical Smear?

Date:

Do you examine your Breasts regularly?

YES / NO

Date:

Signature: