

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

Male

Patient Questionnaire

PERSONAL INFORMATION

Name:- Mr			
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	
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:

Do you examine your Testicles regularly?

YES / NO

Date:

Signature: