NEW PATIENT MEDICAL BACKGROUND - Please hand this completed form to your Doctor

Surname :______________________________ **Date of Birth**: _ _ / _ _ / _ _ _ _

First Names : ______________________________ **Preferred Name**:________________

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ **other :** **Gender:** : ______________ (please specify)

Occupation : ____

Current Medical Condition(s) (ie asthma, diabetes etc) : ______________________________

____

Previous Medical Conditions (ie operations) : ______________________________

____

____

Medication(s) you are currently taking : ______________________________

____

____

Allergies (including medications) : ______________________________

Immunisations (in the past 5 years, including flu vaccine) : ______________________________

____

When was your last check up? ______________________________

Blood pressure	[ ]	Cholesterol	[ ]
Cervical screening	[ ]	Prostate check	[ ]

Do you smoke?	Yes ☐	No ☐	If so, number per day / week [ ]
Do you drink alcohol?	Yes ☐	No ☐	If so, average per day / week [ ]
Do you exercise regularly?	Yes ☐	No ☐	If so, times per day / week [ ]

About your family—tick the relevant boxes below if you have family history of:

Diabetes ☐ Heart Disease ☐ Breast Cancer ☐ Bowel Cancer ☐ Asthma ☐

Glaucoma ☐ Abdominal Aneurysm ☐ Prostate Cancer ☐

Other illnesses (please specify): ______________________________