New Patient Information

Last name			
First name(s)			
Date of Birth		Occupation	
Weight		Height	
Ethnicity			

General Health

Have you ever had any serious illnesses, operations or had investigations such as blood tests or X-rays?
What drugs or medicines are you taking?
What regular exercise do you take?
How would you describe your diet?
Are you allergic to any medicines or anything else?

Smoking & Drinking

How many cigarettes do you smoke per day?						
How much alcohol per week do you drink?						
Wine		Beer		Spirits		
How often do you have 8 (for a man) 6 (for a woman) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what is normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
In the last year has a relative or friend, or a doctor or a health worker been concerned about your drinking or suggested you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	

Family History

Have any of your close relatives suffered from the following?					
Heart Disease		Cancer		Diabetes	
High Blood Pressure		Asthma		Stroke	
Are you a carer?		Are you being cared for?			
Name and telephone number of carer					

Females only

When was your last smear?		Have you had a hysterectomy?	
What method of contraception are you using at present?			