BEACH STREET
FAMILY PRACTICE

NEW PATIENT QUESTIONNAIRE FOR DOCTOR

Please hand the completed form to Doctor.

NAME:____________________________________ **DOB**______________________

MEDICAL HISTORY

Any Allergies? :______________________________

Smoker: YES ☐ NO ☐ If yes, how many per day:_____________

If ex-smoker, when did you quit:__________________

Alcohol: YES ☐ NO ☐ How many standard drinks per week:______________

YOUR HEALTH HISTORY

Tick if it applies to you-

☐ Operations
☐ Asthma
☐ Kidney Disease
☐ Migraine
☐ Bowel Cancer
☐ Breast Cancer
☐ Depression
☐ Heart Attack
☐ High Blood Pressure
☐ Diabetes
☐ Epilepsy
☐ Stroke
☐ Other____

MEDICATIONS

List your current medications:____

____

IMMUNISATIONS

☐ YES ☐ NO Influenza, yearly ☐ YES ☐ NO Pneumonia, every 5 years

FAMILY HISTORY

	Living	Age (or age at death)	List serious illnesses
Mother	☐ YES ☐ NO	__________	_______________
Father	☐ YES ☐ NO	__________	_______________
Sister	☐ YES ☐ NO	__________	_______________
	☐ YES ☐ NO	__________	_______________
Brother	☐ YES ☐ NO	__________	_______________
	☐ YES ☐ NO	__________	_______________

PLEASE COMPLETE REVERSE SIDE ->

FAMILY HISTORY continue-

Has any member of your family (including children & parents) had any of the following illnesses?

Illness	**Which family member?**
Diabetes	______________________
Cancer	______________________
Glaucoma	______________________
High blood pressure	______________________
Heart Disease	______________________
Anaemia or Blood disease	______________________
Stroke	______________________
Mental Illness/Depression	______________________
Other	______________________

Females: Gynaecological History

How many times have you been pregnant?______Date of last Pap smear:_________

Have you had an abnormal Pap smear? ☐ YES ☐ NO

Date of last Mammogram:_________

Have you ever had a breast biopsy? ☐ YES ☐ NO

PATIENTS SIGNATURE OR PARENT/GUARDIAN (if child is a minor).

____

Date:_________________