PATIENT QUESTIONNAIRE:
PLEASE TAKE THE TIME TO FILL IN THIS QUESTIONNAIRE CAREFULLY *BEFORE* YOUR FIRST APPOINTMENT:

FULL NAME: …… DATE OF BIRTH: ……...……

ADDRESS:……..……

POST CODE:……..

TELEPHONE: HOME:(STD CODE…….) ……..……

WORK: (STD CODE…….) ……..……..

MOBILE: ……..

E-MAIL: ……..……..

G.P.'S NAME; ……..

SURGERY ADDRESS: ……..……

TELEPHONE:……

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF SO, PLEASE INDICATE YOUR AGE AT THE TIME, AND WHETHER MILD, NORMAL OR SEVERE:

MEASLES……

MUMPS……

CHICKEN POX……

GERMAN MEASLES……..

SCARLET FEVER……

GLANDULAR FEVER……

RHEUMATIC FEVER……..

TONSILLITIS……

DIPHTHERIA:……

RECURRENT COLDS:……..

EAR PROBLEMS:……

WHOOPING COUGH:……

TUBERCULOSIS:……

HAVE YOU EVER SUFFERED FROM SKIN PROBLEMS? PLEASE GIVE DETAILS:
……
……
HAVE YOU HAD ANY REACTIONS TO ANY INNOCULATIONS? PLEASE GIVE DETAILS, INCLUDING YOUR AGE AT THE TIME
……
……

PLEASE INDICATE IF YOU SUFFER FROM, OR HAVE EVER HAD, ANY OF THE FOLLOWING:

ALLERGIES:……

WARTS:……

MOLES;……

RINGWORM:……

CYSTS:……

PLEASE PROVIDE BRIEF DETAILS, INCLUDING MONTH/YEAR, OF ANY OPERATIONS, ACCIDENTS, SERIOUS ILLNESSES, OR HOSPITALISATION;
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DETAILS OF CURRENT MEDICATION: ……..…
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DETAILS OF PREVIOUS MEDICATION: ……..……
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……

PLEASE PROVIDE DETAILS OF CLOSE RELATIVES' ILLNESSES, INCLUDING HEART PROBLEMS, CANCER, DIABETES, TUBERCULOSIS, MENTAL ILLNESS, ASTHMA, ECZEMA, HAY FEVER, ETC.

FATHER:……
FATHER'S FATHER:……
FATHER'S MOTHER:……..

MOTHER:……..
MOTHER'S FATHER:……
MOTHER'S MOTHER:……

AUNTS AND UNCLES: ……

BROTHERS AND SISTERS: ……

……
(SIGNED)

……
(DATED)