Stonebridge Surgery
Preston Road
Longridge
PRESTON
PR3 3AP

NEW PATIENT HEALTH QUESTIONNAIRE

SURNAME		**Date of Birth**					
Forename		**Nationality & Ethnic Origin**					
Title (Mr, Mrs, Miss, Ms, Dr)		**1st spoken language (main)**					
Marital status		**Are you a carer?**		**yes**		**no**	
Occupation		**Do you have a carer?**		**yes**		**no**	

MEDICAL HISTORY have you suffered from any of the following (please tick ✓)

Heart problems		Migraine		High blood pressure		Epilepsy	
Asthma or COPD		Eczema/hay fever		Cancer		Mental illness	
Diabetes		Stroke		Glaucoma		Significant any other	

FAMILY HISTORY - **Do you have a family history of any of the above? If YES please specify below**

Do you have any ALLERGIES? please specify	

Have you had any OPERATIONS? please specify	

Current MEDICATION	

SMOKING - Have you ever smoked?	**Yes**		**No**

WE ALWAYS ADVISE YOU TO STOP SMOKING

Do you smoke now? If YES, how many?	
Cigarettes per day	
Cigars per day	
Tobacco (grams per week)	

ALCOHOL - do you drink?	**Yes**		**No**

WE ALWAYS ADVISE YOU KEEP ALCOHOL INTAKE TO WITHIN RECOMMENDED GUIDELINES

If YES, how much per week?			
Beer/Cider		Spirits	
Wine		Sherry	

EXERCISE - (please tick ✓)			
No exercise		Moderate exercise	
Light exercise		Heavy exercise	

DIET
Do you think you have a healthy diet? YES / NO

FEMALE PATIENTS

When was your last CERVICAL SMEAR?	

Do you use any form of contraception? please specify	

Signature **Date**