ROLLESTON CENTRAL HEALTH

New Patient Medical Questionnaire (to be completed if aged 18 or older)

Name:	**Date of Birth:**
Occupation:	**Age:**

Current Medications: *(Please list ALL treatments you are taking at present – continue over page if you need to)*

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Your Own Past Medical History: *(Please circle or add if not listed)*

High blood pressure	Heart disease	Stroke
Diabetes	Glaucoma	Asthma
Smoker	How much alcohol do you drink in a week?	
Mental Health *(please specify)*	Cancer *(please specify)*	Operations *(please specify)*

Your Family History: *(Please circle or add if not listed and specify relative i.e. mother/father/sibling)*

High blood pressure	Heart disease	Stroke
Diabetes	Glaucoma	Asthma
Mental Health *(please specify)*	Cancer *(please specify)*	Other *(please specify)*

Medication Allergies (please specify):

Smoking Status:

[ ] Never smoked [ ] Current Smoker – Would you like support to quit? Yes [ ] No [ ]

[ ] Stopped smoking in the last 15 months – would you like support to stay smokefree? Yes [ ] No [ ]

[ ] Stopped smoking over 15 months ago

Immunisations: (Please enter approximate date if known)

Tetanus: Other:

Women only: *(Please enter approximate date if known)*

Number of pregnancies:	Number of live births:
Date of last cervical smear:	Any abnormal smears? *(Please specify):*
Last mammogram:	Any abnormal mammograms? *(Please specify):*
Contraception Method:	Pill / Depo / IUD / Condoms / Cap / Jadelle / None

I have completed this form fully to the best of my knowledge: Signed _____

Nurse checked and to proceed with enrolment: Signed _____