SOUTHEND MEDICAL CENTRE
PATIENT MEDICAL QUESTIONNAIRE

Date:

NAME:..... **DOB:** .....

MEDICAL HISTORY Have you ever had any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Attack	☐	☐ Year.....	Angina	☐	☐
Asthma/Bronchitis	☐	☐	Kidney Disease	☐	☐	Blood Transfusion	☐	☐
Bleeding Disorder	☐	☐	Stomach Ulcer	☐	☐	Bowel Bleeding	☐	☐
Psychiatric Treatment	☐	☐	Anaemia	☐	☐	Rheumatic Fever	☐	☐
Tuberculosis (TB)	☐	☐	Pneumonia	☐	☐	Diabetes	☐	☐
Thyroid Disorder	☐	☐	Blood Clot in legs	☐	☐	Jaundice/Hepatitis	☐	☐
Epilepsy or fits	☐	☐	in lungs	☐	☐	Stroke	☐	☐
Other	☐	☐						

Please give details

SURGICAL HISTORY Have you had any previous surgery? YES ☐ NO ☐

Please give details (state year) include investigations such as colonoscopy etc

All women aged 18-70 years: date of last Pap smear?.....

Any abnormal smears or treatments in past.....

MEDICATION YES ☐ NO ☐

Are you taking any medication at present?

Please give details (include contraceptive pill)

Medication	Dose	Frequency

ALLERGIES YES ☐ NO ☐

Do you have any allergies?

Please give details, i.e medication, tapes, foods, pollens/dust.....

SMOKING

	YES	NO
Smoker?	☐	☐
Ex smoker?	☐	☐
Never smoked	☐	☐

Year or age commenced smoking ..... Number per day .....

Ceased when? .....

DO YOU DRINK ALCOHOL?

	YES	NO		YES	NO
Monthly	☐	☐	1-2 times a week	☐	☐
1 -2 times per month	☐	☐	3-4 times a week	☐	☐
Less than monthly	☐	☐	5-6 times a week	☐	☐
Non drinker	☐	☐			

ARE THERE ANY ILLNESSES IN YOUR EXTENDED FAMILY (PARENTS, UNCLE, etc)?

	YES	NO	
Cancer (Bowel, breast, prostate, etc)	☐	☐	Which type of cancer?.....
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Heart Problems/Strokes	☐	☐	
Any Genetic or Hereditary Illness?	☐	☐	
Bowel Polyps	☐	☐	

ARE YOU AT (INCREASED) RISK OF HIV? YES ☐ NO ☐