RICHMOND HEALTH CENTRE

Adult New Patient Questionnaire

Please complete the information below to help us identify any problem areas.

Name: …… Date of Birth ……...

Occupation: (if retired your past occupation) ……

Employer: ……

Do you have any personal history of any of the following:	**Or** **Do you have a Family History of the same?** **If yes, what relationship (eg. Mother, father) and age of diagnosis.**
Heart Attack ……Yes / No	Yes / No ……
Angina ……Yes / No	Yes / No ……
Stroke ……Yes/ No	Yes / No ……
Diabetes (including during pregnancy)Yes / No	Yes / No ……
High Blood Pressure ……....Yes / No	Yes / No ……
Cancer …….....Yes/ No	Yes / No ……
If yes, what type?.....	
Any abnormal skin spots/moles.....Yes/No	
Are you on any regular medication (including the contraceptive pill)?	**Known Medical Problems/Past Major Surgery or Illnesses:**
Yes / No	……..
Please List your current medications:	……..
…….	……
……	……
……	…….
……	……
…….	……
…….	……
…….	……

Allergies to medications or experienced any other allergic reactions Do you have any allergies ? **YES/NO** If Yes please list: …….. ……..	**Immunisations** When did you last have a tetanus booster? …….. Tetanus Boosters are recommended at ages 45 and 65 years
Lifestyle: Exercise How much exercise do you do? Daily / 2-3 times in a week / once weekly Or less often Do you think your exercise is: Light / moderate / or strenuous	**Smoking – the best thing you can do for your health is quit!** Current smoker …… per day Would you like help/support to quit? …… Never smoked Ex-Smoker – stopped …….. How many per day were you smoking at that time? ….. **What is your alcohol intake per week?** Glasses of Wine ……. Measures of Spirits ……. Beer – cans / stubbies ……
Women Only Date of your last Cervical Smear …….. Have you ever had an abnormal smear requiring treatment? Yes / No / Not Sure Have you had a hysterectomy and been advised that you no longer need to have smears? Yes / No / Not Sure Do we have your consent to request your cervical screening history from the National Screening Programme? Yes / No / Declined Smears	**Women Only** Date of your last mammogram …….. Do you have a history of breast cancer? Yes / No If aged between 45 and 69 years, are you enrolled in the National Breast Screening Programme? Yes / No / Not Sure If not enrolled in Breast Screening and are eligible, do we have your consent to enrol you on this programme? Yes / No, I decline Enrolment