COURTFIELD MEDICAL CENTRE
New Patient Questionnaire

Date: _____ How did you hear about us? _____

Name:_____ Date of Birth: _____

Home Tel:_____ Work Tel:_____

1. Height: _____ Weight: _____

2. Do you smoke? Never have □
   Stopped □ When _____
   Yes □ How many _____

3. Alcohol
   (1 unit = 1 single measure of wine, spirits, sherry and ½ a pint of beer, lager or cider)
   Do you drink alcohol?
   Never have □
   Stopped □ When _____
   Yes □ Number of units per wk

4. Current medical problems and past medical history
   Please list any operations or illnesses you have had (including dates)

5. Family history
   Are your parents alive & well? Yes □ No □
   Has there been any serious illness in your family?
   (we are particularly interested in; heart disease/stroke, high blood pressure & diabeties)

6 Medication
   Please list all current medication

7. Allergies
   Please list all allergies

8. Date of last cervical smear _____ Result _____
   performed by: GP, privately, abroad, hospital of clinic. (please circle)

   Have you had any previous abnormal smear results?
   Year _____ Details _____.