COURTFIELD PRIVATE PRACTICE

NEW PATIENT MEDICAL QUESTIONNAIRE

DATE: .....

NAME: .....

DATE OF BIRTH: .....

1. **Current medical problems:**

.....
.....
.....

2. **Past medical history**:

(Please list any operations or illnesses you have had - including dates)

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.....
.....

3. **Family history:**

Has there been any serious illness in your family?

(*We are particularly interested in: heart disease/stroke, high blood pressure & diabetes*)

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4. **Current medications:**

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.....
.....

5. **Allergies:**

(Please list all allergies)

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.....
.....

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6. **Vaccinations:**

Name	**Dates given**
.....	.....
.....	.....
.....	.....
.....	.....

7. **Height:** ..... **Weight:** .....

8. **Do you exercise?** No ☐
Yes ☐ If yes, how many hours per week? .....

9. **Do you smoke?** Never have ☐
Stopped ☐ If stopped, when? .....
Yes ☐ If yes how many per day? .....

10. **Do you drink alcohol?** Never have ☐
Stopped ☐ When? .....
Yes ☐ Number of units per week? .....

SIGNATURE (Parent to sign for children under 16 years of age)

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DATE ……..