COURTFIELD
PRIVATE PRACTICE

NEW PATIENT MEDICAL QUESTIONNAIRE - ADULT

DATE ……..

FULL NAME ……

DATE OF BIRTH ……..

1. Current Medical Problems

2. Past Medical History

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

3. Family History

Has there been any serious illness in your family?
(We are particularly interested in: heart disease/stroke, high blood pressure & diabetes)

4. Current Medications

5. Allergies (*Please list all allergies*)

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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? ……..

CONSENT

By signing below I consent to my health records being accessed and updated by all clinicians at Courtfield Private Practice. I understand Courtfield Private Practice may share information about me and my care with other health professionals.

*(Please note: We will **only** use or pass on identifiable information about you with other health professionals who are involved in the direct provision of your care).*

SIGNATURE ……..

DATE ……..