NEW PATIENT INFORMATION CARD

Date _____

Surname _____

First Name _____

Full Address_____

_____

Telephone No. _____

Marital Status _____

Date of Birth _____

Occupation _____

Ethnic Origin _____

General History
Have you had any serious illnesses or operations, X-rays or similar tests and when?

_____

_____

_____

_____

Have you any allergies to medicines or anything else?

_____

_____

What medicines are you taking?

Tablet	Strength	Frequency

How much tobacco or cigarettes do you smoke?

Never smoked_____ Ex smoker_____ Smoker (amount)_____

How much alcohol do you consume per week?

Wine _____ Beer _____ Spirits _____

Family History
Which of your blood relations have suffered from the following

Heart Attack _____ Cancer _____

Diabetes _____ High BP _____

Asthma _____ Tuberculosis _____

Stroke _____ Other Serious Illness _____

For Female Patients Only

Have you had any children? _____
Have you had a miscarriage? _____
Have you had a hysterectomy? _____
When was your last smear? _____