NEW PATIENT INFORMATION SHEET

Date ____

Surname ____

First Name ____

Full Address____

____

Telephone No. ____

Marital Status ____

Date of Birth ____

Occupation ____

Ethnic Origin ____

What medicines are you taking?

Please obtain a Patient Summary listing all medications from your current practice and attach to this form.

Have you any allergies to medicines or anything else?

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

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How much tobacco or cigarettes do you smoke per day?

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? __________________________