Dr. Keith McIntyre
New Patient Health Questionnaire

Your Contact Details*

Title
Mr □ Mrs □ Miss □ Ms □ Other □

Surname

Date of Birth

First Names

Occupation

Previous Surnames

Home Address

Postcode

Home Tel
Mobile
Email
Please provide an email address where possible

Medical Information*

Please list any serious illnesses / operations / accidents / disabilities and for women any pregnancy related problems:

Please list any medicines being taken including strength and quantity*

Are you registered disabled?* (If yes, please give details) Yes / No

Are you allergic to any medicines and if so, which?*
Yes / No

Carers*

Do you have a carer? (If yes please give details) Yes / No

Are you a carer? (If yes please give details) Yes / No

Women*

Have you ever had a cervical smear? Yes / No
(Please state the last date)

Smoking*

Do you smoke? Yes / No

If 'No', have you ever smoked? Yes / No

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?

Would you like advice on giving up smoking? Yes / No

Alcohol*

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

Family History*

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.)

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Signature:

Date: