**DATE……………………………………**

**STROMNESS SURGERY**

**QUESTIONNAIRE FOR NEWLY REGISTERED PATIENTS**

**SURNAME** **FIRST NAMES**

**ADDRESS** **MARITAL STATUS**…………………………………

**DOB**........................**OCCUPATION** **ETHNIC ORIGIN ………………………………………**

**FIRST LANGUAGE ………………………………… DO YOU NEED TRANSLATION SERVICES? YES/NO**

**POSTCODE** **TEL**........................(**home**)...............................(**work**)

## EMAIL MOBILE

**NEXT OF KIN**: **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you a carer for anyone? Yes/No**

**Is anyone a carer for you? Yes/No**

**Details ………………………………………………………………………………………………………………………………………..**

# MEDICAL HISTORY

Have you had any operations or serious Are you taking any tablets, medicine, injections or

illness'? inhalers?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **YEAR** | **CONDITION** |  | **NAME OF MEDICINE** | **HOW OFTEN TAKEN** | **WHAT DO YOU TAKE THEM FOR** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**FAMILY HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| FAMILY MEMBER | AGE | NORMAL STATE OF HEALTHWELL/UNWELL | CAUSE OF DEATHIF APPLICABLE | AGE AT DEATH |
| **MOTHER** |  |  |  |  |
| **FATHER** |  |  |  |  |
| **BROTHERS/SISTERS** |  |  |  |  |
| **HUSBAND/WIFE** |  |  |  |  |
| **CHILDREN** |  |  |  |  |

**PLEASE TURN OVER NOW**

Have any close relatives had:

A **HEART ATTACK YES/NO**  (please delete) Who?

If **YES**, age at first attack

A **STROKE YES/NO** (please delete) Who?

If **YES**, age at onset

**CANCER YES/NO** (please delete) Who?

If **YES**, please specify where………………

Do you **smoke YES/NO**? (please delete) If **YES**, how many a day?

If **NO**, are you an ex-smoker **YES/NO**? When did you stop?

**ALLERGIES**: Are you allergic to any medicine, tablets, injection, or adhesive tape. If so which?

If you are **FEMALE:**

When did you last have a **cervical smear**

By whom? GP/Hospital Doctor/Clinic (please delete)

Are you taking the **contraceptive pill**  **YES/NO**

If **YES,** which one?

Have you an **IUCD** (coil)? **YES/NO**

If **YES**, when was this inserted?

Have you had a **hysterectomy** **YES/NO**

If **YES,** when?

Are you taking, or have you had **HRT** **YES/NO**

(hormone replacement therapy)

If **YES**, which variety?

**Please complete all details where possible.**

**Thank you for taking the time to complete this questionnaire.**