The Health Care Complex

New Patient Questionnaire

Personal Details	
Full Name	
Previous Name	
Date of Birth	
Address	
Postcode	
Home Number	
Mobile Number	
Work Number	
Sex	
Marital Status	
Ethnic Origin	
Main Language	

Consent for SMS Messaging and Online Services (Please circle)		
Consent for sending SMS messaging	Yes	No
Consent for using online services	Yes	No

Email Address	

When you had your last one:			
Measles		Typhoid	
BCG		Cholera	
MMR		Yellow Fever	
Whooping Cough			

Lifestyle Information			
Do you smoke?			
Never Smoked		Ex-smoker	
Smoke less than 1/day		Smoke 1-9/day	
Smoke 10-19/day		Smoke 20-39/day	
Smoke 40 or more/day			
Do you Drink? Yes No			
If yes, please complete the alcohol questionnaire			

Do You Drink?	
Yes	No
If yes, please complete the alcohol questionnaire	

Medical History			
Do you suffer with any of the following:			
Angina		Epilepsy	
Diabetes		Heart Attack	
Cancer		Stroke	
COPD		Mental Illness	
Asthma		Hypertension	
Hypothyroidism		Visually Impaired	
Hearing Impaired		Learning Disabilities	

Any Known Allergies?	
Yes	No
If yes, please indicate:	