Pegasus Medical Centre

New Patient – Medical Questionnaire – updated 1.06.22

Age 14+ to complete and return with your enrolment form

Patient Name:	**Patient DOB:**	**Date:**

1. Do you have any, or have had, any of the following **medical conditions**:

	Self	**Family**		**Self**	**Family**
Diabetes	☐Yes ☐No	☐Yes ☐No	Blood clot/disorder	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No	☐Yes ☐No
Heart Disease or circulation	☐Yes ☐No	☐Yes ☐No	High cholesterol	☐Yes ☐No	☐Yes ☐No
Heart Attack ☐<60yr ☐>60yr	☐Yes ☐No	☐Yes ☐No	Migraine	☐Yes ☐No	☐Yes ☐No
Asthma, lung or respirator	☐Yes ☐No	☐Yes ☐No	Epilepsy	☐Yes ☐No	☐Yes ☐No
Kidney Disease	☐Yes ☐No	☐Yes ☐No	Cancer inc. skin cancer (type)	☐Yes ☐No	☐Yes ☐No
Liver disease or Hepatitis	☐Yes ☐No	☐Yes ☐No	Glaucoma	☐Yes ☐No	☐Yes ☐No
Bowel disease or problems	☐Yes ☐No	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No	☐Yes ☐No
Joint disease or arthritis	☐Yes ☐No	☐Yes ☐No	Tuberculosis (TB)	☐Yes ☐No	☐Yes ☐No
Depression and/or anxiety	☐Yes ☐No	☐Yes ☐No	Eczema	☐Yes ☐No	☐Yes ☐No
Other mental health illnesses	☐Yes ☐No	☐Yes ☐No	Hay Fever	☐Yes ☐No	☐Yes ☐No

2. Do you have any **other health, disability problems or inherited conditions**? Please list

   ____

   ____

3. Please list any **regular medications** that you take:

   ____

   ____

4. Have you had **any operations**? ☐ **Yes** *(year and type)* ☐ **No**

   ____

   ____

5. Are you **allergic to anything**, especially medications? ☐ **Yes** *(type of reaction)* ☐ **No**

   ____

   ____

6. Do you **drink alcohol** ☐ **Yes** ☐ **No**

   if yes, on average, how much/week __________, what type ___________________

7. Do you have any **substance abuse** problems? ☐ **Yes** ☐ **No**

8. Are you a **smoker?** ☐ **Yes** ☐ **No** ☐ **Ex-Smoker**

   If yes, how many smokes per day? ___________ How many years have you smoked? ____________

9. When was your last **Tetanus Booster**? ______________

10. Are your childhood immunisations up to date? ☐ **Yes** ☐ **No** ☐ **Don't Know**

11. **Woman:** (those over 25yrs and sexually active)

When was your most recent cervical smear? _______________

Have you had an abnormal smear?	☐ **Yes**	☐ **No**	☐ **Don't Know**
Have you had a mammogram (those over 45yrs)?	☐ **Yes**	☐ **No**	**if yes when ______**

12. Men: When was your last health check-up? **_____________**

13. Any **other information** you wish to share with the Nurse/Doctor prior to the first appointment:

____

____

____

____

____

NURSE TO COMPLETE……

New patient appt booked?	*(☐Nurse ☐GP ☐Both)*	*☐ Yes*	*☐ No*	*☐ not required*
General Observation:	*Height: ________*	*Weight: _______*	*BP: ________*	*Waist: _______*
CVRA appropriate?	*☐ Yes*	*☐ No*		
Extra Bloods needed?	*☐ Yes*	*☐ No*		
Smear Booked if needed?	*☐ Yes*	*☐ No*	*☐ N/A*	
Give mam booking info	*☐ Yes*	*☐ No*	*☐ N/A*	

Nurse Initials: ______

Notes: