Pipeland Medical Practice
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Pipeland
MEDICAL PRACTICE

Complete and save/print using Acrobat or print and fill-in by hand. Return by post or drop into the practice at the above address.

ADULT MEDICAL QUESTIONNAIRE

This questionnaire is to help us get to know you. Please leave out any questions which you do not understand or consider too personal. (Additional space for answers is provided on page 3).

1. Contact information

Name _____ Date of birth _____ Marital Status _____

Occupation _____

Tel: *Home* _____ *Work* _____

Mob _____ Email address _____

I consent to be contacted by: Mobile phone ☐ Text ☐ Email ☐

2. Ethnic origin

White Scottish ☐ White British ☐ White other - please state _____

Asian British ☐ Asian other - please state _____

Black British ☐ Black other - please state _____

Other ethnic group - please state _____ I prefer not to state my ethnic group ☐

Do you need an interpreter or sign language support? Yes ☐ No ☐

If yes, what language do you speak? _____

3. Who is your next of kin?

Name _____ Relationship to you _____

Telephone _____ Mobile no. _____

4. Have either of your parents, brothers or sisters have or had

		Family member			Family member
Asthma	Yes ☐ No ☐	_____	Epilepsy	Yes ☐ No ☐	_____
High blood pressure	Yes ☐ No ☐	_____	Diabetes	Yes ☐ No ☐	_____
Heart Disease (Age 60 or less)	Yes ☐ No ☐	_____	Cancer	Yes ☐ No ☐	_____
Stroke	Yes ☐ No ☐	_____			

5. Are you taking any regular prescribed medicines (incl. contraception) Yes ☐ No ☐

Name _____ Dose _____

Name _____ Dose _____

Name _____ Dose _____

Name _____ Dose _____

6. Are you taking regular over-the-counter medicines from the chemist? Yes ☐ No ☐

Name _____ Dose _____

Name _____ Dose _____

Name _____ Dose _____

Name _____ Dose _____

7. Have you had any serious illnesses, injuries or operations? Yes ☐ No ☐

Date _____ Description _____

Date _____ Description _____

Date _____ Description _____

8. Do you have any allergies Yes ☐ No ☐

If yes, type of allergy _____

9. Smoking

Do you smoke? Yes ☐ No ☐ If yes, how many a day? _____

Are you an ex smoker? Yes ☐ No ☐ If yes, when did you stop? _____

10. Drinking

Do you drink alcohol? Yes ☐ No ☐ If yes, how much? _____

11. Do you exercise?

Do you exercise? Yes ☐ No ☐ If yes, how much? _____

12. Immunisations - state dates received in the boxes below

1st Diphtheria Date:	1st Tetanus Date:	1st Pertussis Date:	1st Polio Date:	1st Hib Date:
2nd Diphtheria Date:	2nd Tetanus Date:	2nd Pertussis Date:	2nd Polio Date:	2nd Hib Date:
3rd Diphtheria Date:	3rd Tetanus Date:	3rd Pertussis Date:	3rd Polio Date:	3rd Hib Date:
1st Meningitis C Date:	2nd Meningitis C Date:	Booster Hib/Men C Date:		
1st Pneumococcal Date:	2nd Pneumococcal Date:	3rd Pneumococcal Date:		
1st Measles / Mumps / Rubella Date:		2nd Measles / Mumps / Rubella Date:		
Booster Diphtheria Date:	Booster Tetanus Date:	Booster Pertussis Date:	Booster Polio Date:	
1st Hepatitis A Date:	2nd Hepatitis A Date:	Booster Hepatitis A Date:		
1st Hepatitis B Date:	2nd Hepatitis B Date:	3rd Hepatitis B Date:	Booster Hepatitis B Date:	
1st Typhoid Date:	Booster Typhoid Date:	Yellow Fever Date:		

Any other immunisations

13. Is there anything in particular you feel we should know, e.g. are you a Carer?

_____

_____

FEMALES ONLY

14. Do you require contraceptive advice

Yes ☐ No ☐

15. Are you currently using contraception

Yes ☐ No ☐ If yes, which type _____

16. Have you had a cervical smear?

Yes ☐ No ☐

If yes, please answer a-d below

a. State date of most recent smear _____

b. Place carried out _____

c. What was the result _____

d. When is your next cervical smear due? _____

I do not require a cervical smear ☐

I have never been sexually active ☐ Signature _____

17. Have you had a mammogram

Yes ☐ No ☐

If yes, please state date of most recent test _____ Place carried out _____

Result _____ Next screen due _____

Additional information