Blackthorn Health Centre **NEW PATIENT QUESTIONNAIRE – FEMALE**

Name: ______________________________ Date of Birth: ____/____/____

Address: ____

______________________________ Post Code: ______________

Telephone No: ______________ **Ethnic Origin:** ______________ **Ethnic Origin Declined(____)**
Ask at reception for list **Please tick if you do not wish to state**

Marital Status: ______________________________ Occupation: ______________

Children (**SEX & DOB**): ____

____

Next of Kin: Name: ______________________ Relationship: ______________

Address: ____

______________________ Telephone No: ______________

Do You have a Carer? YES / NO

If Yes, Name: ______________________ Relationship: ______________

Address: ____

______________________ Telephone No: ______________

Are You a Carer? YES / NO

If Yes, Name: ______________________ Relationship: ______________

Address: ____

______________________ Telephone No: ______________

Have you ever Smoked? YES / NO

Do you smoke now? YES / NO

If **YES** How Many per Day? ______________ If No **DATE** when you stopped ______________

Do You Drink Alcohol? YES / NO How much per week? ______________

HEIGHT ______________________ WEIGHT ______________________

*Allergies: ____

*Previous Illnesses and or Operations **(Including dates):** ______________________________

____

Current Medication: ____
IF ON REPEAT MEDICATION – PLEASE ALSO MAKE APPOINTMENT WITH GP TO SET UP.

Date & Result of Last Cervical Smear: ______________________________

Date & Result of Last Mammogram: ______________________________

Please State All Known Family History of the Following:

Asthma: ______________ Eczema: ______________ Diabetes: ______________

Cancer: ______________ Glaucoma: ______________ High Blood Pressure: ______________

Heart Disease: ______________ Stroke: ______________ Other: ______________