

**Blackthorn Health Centre**

**NEW PATIENT QUESTIONNAIRE – MALE**

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 APPONTMENT WITH GP TO SET UP.***

**Please State All Known Family History of the Following:**

Asthma: \_\_\_\_\_ Eczema: \_\_\_\_\_ Diabetes: \_\_\_\_\_

Cancer: \_\_\_\_\_ Glaucoma: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_

Heart Disease: \_\_\_\_\_ Stroke: \_\_\_\_\_ Other: \_\_\_\_\_