Questionnaire for Newly Registered Men

Name _____ Date of Birth _____

Address _____ Telephone No. _____Mobile_____

_____Post Code_____ e.mail _____

Occupation _____ Marital Status _____

Do you have any medical problems at present? ☞ ☐ Yes ☐ No
(If yes, please describe on back of this sheet. Page2)

Are you taking any medicines? ☞ ☐ Yes ☐ No
(If yes, please describe on back of this sheet. Page2)

Have you had any serious illnesses, operations or accidents? ☞ ☐ Yes ☐ No
(If yes, please describe on back of this sheet. Page2)

Do you have any allergies? ☞ ☐ Yes ☐ No
If so, please give details. _____

Have you any history in your family of
heart disease, ☞ ☐ Yes ☐ No
of diabetes, ☞ ☐ Yes ☐ No
or of any other serious illnesses? ☞ ☐ Yes ☐ No
(If yes, please give details.) _____

Have you ever been a smoker? ☞
☐ No, I have never smoked
☐ Yes, ex-smoker. (How many did you smoke?.....)
When did you stop?.....
☐ Yes, current smoker (How many do you smoke?.....)

Do you drink alcohol? ☞ ☐ Yes ☐ No
(If so, how much a week on average?) _____

Do you do any regular exercise? ☞ ☐ Yes ☐ No
If you do, then would you describe it as light, moderate or heavy? _____

Have you had all your childhood vaccinations?☞ ☐ Yes ☐ No

Date questionnaire completed:-.....

Thank you for completing the form, now please make an appointment to see us at the Medical Centre for the following checks.

Height	Weight	BP	Urinalysis

Date examination completed:-.....

Dr G.J.Mackintosh * Dr L.E.Mackintosh

Questionnaire for Newly Registered Women

Name _____ Date of Birth _____

Address _____ Telephone No. _____Mobile_____

_____Post Code_____ e.mail _____

Occupation _____ Marital Status _____

Do you have any medical problems at present? ☞ □ Yes □ No
(If yes, please describe on back of this sheet. Page2.)

Are you taking any medicines? ☞ □ Yes □ No
(If yes, please describe on back of this sheet. Page2)

Have you had any serious illnesses, operations or accidents? ☞ □ Yes □ No
(If yes, please describe on back of this sheet. Page2)

Do you have any allergies? ☞ □ Yes □ No
If so, please give details. _____

Have you any history in your family of
heart disease, ☞ □ Yes □ No
of diabetes, ☞ □ Yes □ No
or of any other serious illnesses? ☞ □ Yes □ No
(If yes, please give details.) _____

Have you ever been a smoker? ☞
□ No, I have never smoked
□ Yes, ex-smoker. (How many did you smoke?.....)
When did you stop?.....
□ Yes, current smoker (How many do you smoke?.....)

Do you drink alcohol? ☞ □ Yes □ No
(If so, how much a week on average?) _____

Do you do any regular exercise? ☞ □ Yes □ No
If you do, then would you describe it as light, moderate or heavy? _____

Have you had all your childhood vaccinations?☞ □ Yes □ No

When was your last cervical smear? ☞ _____

When did you last have mammography or a breast examination? ☞ _____

Do you have any children? ☞ Yes □ No □
(If yes, please give ages) _____

Have you had any miscarriages? ☞ Yes □ No □

Date questionnaire completed:-.....

Thank you for completing the form, now please make an appointment to see us at the Medical Centre for the following checks.

Height	Weight	BP	Urinalysis

Date examination completed:-.....

Dr G.J.Mackintosh * Dr L.E.Mackintosh

Questionnaire for Newly Registered Children under 16 years old

Name _____ Date of Birth _____

Address _____ Telephone No. _____Mobile_____

_____Post Code_____ e.mail _____

Does your child have any medical problems or special needs at present? ☞ ☐ Yes ☐ No
(If yes, please describe on back of this sheet. Page2)

Does your child take any medicines? ☞ ☐ Yes ☐ No
(If yes, please describe on back of this sheet. Page2)

Has your child had any serious illnesses, operations or accidents? ☞ ☐ Yes ☐ No
(If yes, please describe on back of this sheet. Page2)

Does your child have any allergies? ☞ ☐ Yes ☐ No
If yes, please give details. _____

Is there any history in your child's immediate family of heart disease, ☞ ☐ Yes ☐ No
of diabetes, ☞ ☐ Yes ☐ No
or of any other serious illnesses? ☞ ☐ Yes ☐ No
If yes, please give details.

_____

Immunisations

Dates if possible (or just tick if had vaccination but not sure of dates)			
2 months	1st Diphtheria, tetanus, pertussis (whooping cough), polio and Hib	**1st** Pneumococcal	
3 months	**2nd** Diphtheria, tetanus, pertussis (whooping cough), polio and Hib	**1st** Meningitis C	
4 months	**3rd** Diphtheria, tetanus, pertussis (whooping cough), polio and Hib	**2nd** Pneumococcal **2nd** Meningitis C	
Around 12 months	**4th** Hib & **3rd** Meningitis C **1st** MMR	**3rd** Pneumococcal	
3 years 4 months to 5 years	**4th** Diphtheria, tetanus, pertussis (whooping cough), polio	**2nd** MMR	
12 to 18 years	**5th** Diphtheria, tetanus, polio		
Girls – 12 to 13 years	3 injections against HPV		
Other			

Date questionnaire completed :-…….Thank you for completing the form.

Dr G.J.Mackintosh * Dr L.E.Mackintosh

Medical Problems: -

Medicines: -

Serious illnesses, operations or accidents: -