

ROLLESTON CENTRAL HEALTH

New Patient Medical Questionnaire (to be completed if aged 18 or older)

Name:	Date of Birth:
Occupation:	Age:

Current Medications: *(Please list ALL treatments you are taking at present – continue over page if you need to)*

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Your Own Past Medical History: *(Please circle or add if not listed)*

High blood pressure	Heart disease	Stroke
Diabetes	Glaucoma	Asthma
Smoker	How much alcohol do you drink in a week?	
Mental Health <i>(please specify)</i>	Cancer <i>(please specify)</i>	Operations <i>(please specify)</i>

Your Family History: *(Please circle or add if not listed and specify relative i.e. mother/father/sibling)*

High blood pressure	Heart disease	Stroke
Diabetes	Glaucoma	Asthma
Mental Health <i>(please specify)</i>	Cancer <i>(please specify)</i>	Other <i>(please specify)</i>

Medication Allergies (please specify):

Smoking Status:

- [] Never smoked [] Current Smoker – Would you like support to quit? Yes [] No []
- [] Stopped smoking in the last 15 months – would you like support to stay smokefree? Yes [] No []
- [] Stopped smoking over 15 months ago

Immunisations: (Please enter approximate date if known)

Tetanus: Other:

Women only: (Please enter approximate date if known)

Number of pregnancies:	Number of live births:
Date of last cervical smear:	Any abnormal smears? <i>(Please specify):</i>
Last mammogram:	Any abnormal mammograms? <i>(Please specify):</i>
Contraception Method:	Pill / Depo / IUD / Condoms / Cap / Jadelle / None

I have completed this form fully to the best of my knowledge: Signed _____

Nurse checked and to proceed with enrolment: Signed _____