

KIRKSTALL LANE MEDICAL CENTRE QUESTIONNAIRE

This form is confidential information to be included in your medical records.

NAME:.....

Address;.....

.....

TEL NO:..... DOB.....

OCCUPATION.....

MARITAL STATUS.....

SMOKING.....PER DAY ALCOHOLUNITS PER WEEK
(1 glass, 1/2 pint or 1 measure = 1unit)

Ex SMOKER.....YEAR (How many per day.....)

DIET *Please delete * Vegetarian, Healthy, Good, Anything REGULAR EXERCISE.....

HEIGHT..... WEIGHT.....

IMMS

Men C date.....

MMR (2) date.....

PAST MEDICAL HISTORY e.g Diabetes/Asthma/High Blood Pressure,

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PAST OPERATIONS.....

ALLERGIES.....

CURRENT MEDICATION.....

FEMALE – DATE & PLACE OF LAST CERVICAL SMEAR

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FAMILY HISTORY OF DIABETES, ASTHMA, HIGH BLOOD PRESSURE, HEART DISEASE, CANCER
etc,

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MOTHER

FATHER