Patient Questionnaire

PLEASE TAKE THE TIME TO FILL IN THIS QUESTIONNAIRE CAREFULLY BEFORE YOUR FIRST APPOINTMENT.

FULL NAME: ..... DATE OF BIRTH: .....

ADDRESS:.....

POST CODE:.....

MOBILE: .....

E-MAIL: .....

G.P.'S NAME: .....

SURGERY ADDRESS:.....

TELEPHONE:.....

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF SO, PLEASE INDICATE YOUR AGE AT THE TIME, AND WHETHER MILD, NORMAL OR SEVERE.

- MEASLES: Y/N Age?..... Mild, normal, severe
- MUMPS: Y/N Age?..... Mild, normal, severe
- CHICKEN POX: Y/N Age?..... Mild, normal, severe
- GERMAN MEASLES: Y/N Age?.....Mild, normal, severe
- SCARLET FEVER: Y/N Age?..... Mild, normal, severe
- GLANDULAR FEVER: Y/N Age?..... Mild, normal, severe
- RHEUMATIC FEVER: Y/N Age?..... Mild, normal, severe
- TONSILLITIS: Y/N Age?..... Mild, normal, severe
- DIPHTHERIA: Y/N Age?..... Mild, normal, severe
- RECURRENT COLDS: Y/N Age?..... Mild, normal, severe
- EAR PROBLEMS: Y/N Age?..... Mild, normal, severe
- WHOOPING COUGH: Y/N Age?..... Mild, normal, severe
- TUBERCULOSIS: Y/N Age?..... Mild, normal, severe

Patient Questionnaire

HAVE YOU EVER SUFFERED FROM SKIN PROBLEMS? PLEASE GIVE DETAILS:

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HAVE YOU HAD ANY REACTIONS TO ANY INNOCULATIONS? PLEASE GIVE DETAILS, INCLUDING YOUR AGE AT THE TIME:.....

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PLEASE INDICATE IF YOU SUFFER FROM, OR HAVE EVER HAD, ANY OF THE FOLLOWING:

ALLERGIES:..... WARTS:.....

MOLES:..... RINGWORM:.....

CYSTS:.....

PLEASE PROVIDE BRIEF DETAILS, INCLUDING MONTH/YEAR, OF ANY OPERATIONS, ACCIDENTS, SERIOUS ILLNESSES, OR HOSPITALISATION FOR ANY REASON:

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DETAILS OF CURRENT MEDICATION: .....

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Patient Questionnaire

DETAILS OF PREVIOUS MEDICATION:.....

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PLEASE PROVIDE DETAILS OF CLOSE RELATIVES' ILLNESSES, INCLUDING HEART PROBLEMS, CANCER, DIABETES, TUBERCULOSIS, MENTAL ILLNESS, ASTHMA, ECZEMA, HAY FEVER, ETC.

- FATHER:.....
- FATHER'S FATHER:.....
- FATHER'S MOTHER:.....
- MOTHER:.....
- MOTHER'S FATHER:.....
- MOTHER'S MOTHER:.....
- AUNTS AND UNCLES: .....

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- BROTHERS AND SISTERS: .....

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(SIGNED) ..... (DATED).....