Leven Medical Practice

Patient Questionnaire

Welcome to Leven Medical Practice. You can find out more information about us from our website or our Practice leaflet.

To help us get to know you, please fill in this form and hand it into Reception.

PATIENT DETAILS:

First Name:	
Surname:	
Address:	
Home Telephone No:	
Mobile Telephone No:	
Date of Birth:	
Marital Status:	

Male ☐ Female ☐

Next of Kin

Name:……..Relationship: ……

Telephone Number: ……..

Do you have, or have you ever suffered from any of the following:
(please tick all that apply)

Angina	☐	Stroke/TIA	☐	Epilepsy	☐
Heart Attack	☐	High Blood Pressure	☐	Depression	☐
Diabetes	☐	Asthma	☐	Learning Disability	☐

Allergies
If you have any known allergies, please list them here

Have you ever had any major illnesses or operations in hospital?
If YES please give details

Are you on any drugs or medication including the oral contraceptive?
If YES please give details

Smoking History

What is your smoking status? ☐ Smoker ☐ Ex-smoker ☐ Never smoked

For Female Patients only

Date of last cervical smear:
(please give details of smear result and if smear was taken outside the UK)

Family History

Have your parents, brothers or sisters suffered from any of the following:

Stroke (aged less than 70) ☐	Heart Attack (aged less than 45) ☐	Asthma ☐
Angina ☐	Diabetes ☐	High blood pressure ☐

If YES to any, please state relationship and give age when they first had the illness diagnosed:

Are you a carer? Yes ☐ No ☐
A carer is a friend or relative who looks after an ill, disabled or older person on an informal, voluntary and long term basis.