TURRIFF MEDICAL PRACTICE
PATIENT QUESTIONNAIRE – NEW PATIENT MEDICAL

Date:	Present Address:
Surname:	
Forename:	
Date of Birth:	Home Number: Mobile Number:

Smoking History ☐ Non Smoker ☐ Current Smoker ☐ Ex-Smoker ☐ Vaping If smoker, how many per day _____	Alcohol Intake ☐ Current Drinker ☐ Teetotal ☐ Ex-Drinker If current drinker, how many units per week _____
Diet Would you say your diet was:- ☐ Very Good ☐ Could Improve ☐ Poor	Exercise ☐ Inactive ☐ Moderate ☐ Vigorous ☐ Gentle
Height _____	Weight _____

Medical History *(Your Own)*

Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Disease <60	☐ Yes	☐ No
Heart Disease > 60	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No

Family History *(Father, Mother, Brother, Sister)*

Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart Disease <60	☐ Yes	☐ No
Heart Disease > 60	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No

Medication

If you are on repeat medication please provide evidence of this from your previous practice e.g. repeat re-order form, medication boxes

Bought Medication e.g. Aspirin					
Known Allergies:					

Review Date July 2026

Contraception

Would you like to discuss contraception with a health professional? *Yes / No* *(Please Circle Appropriately)*

☐ Coil
Date Inserted _____
Removal Due Date _____

☐ Contraceptive Implant
Date Inserted _____
Removal Due Date _____

☐ Contraceptive Pill
Current Medication _____

Ring Pessary

Do you currently have a ring pessary inserted Yes / No *(Please Circle Appropriately)*

Carer

Do you consider yourself to be a carer: Yes / No

If yes for Whom? _____

Blood Transfusion

If you were born before 1996 have you had a blood transfusion Yes / No

Please detail any other information you may think relevant.

Signed …… (Patient) Date ……..

Please bring this completed questionnaire with you when you Register.