**CARNEGIE MEDICAL CENTRE – Medical Questionnaire**

\*\*Please note this questionnaire is two pages – please make sure that complete both sides.

NAME: …………………………………………………………………………………………………………………………………………

1. **Significant Family History**

Mother alive? Yes No age at death? …………. Cause? ………………………………………….

Father alive? Yes No age at death? …………. Cause? ………………………………………….

In your family, is there a record of (tick where applicable):

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Father | Mother | Siblings | Paternal G/father | Paternal G/mother | Maternal G/father | Maternal G/mother |
| Diabetes |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |
| Cancer/Type |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |

1. **Alcohol** – Do you drink alcohol? (please circle) Yes No

How many days per week do you drink alcohol? ……………………………..

How many standard drinks would you drink per day? ……………………………..

Past alcohol intake? (please circle) Never Occasional Moderate Heavy

1. **Smoking** (please circle one)

Smoker year commenced smoking ……………………….. no per day…………………………………

Ex-Smoker year commenced smoking ……………………….. year quit smoking …………………….

Non Smoker NEVER Smoked

1. **Allergies** – do you suffer from any allergies (please circle) Yes No

Give details

|  |  |
| --- | --- |
| Name of item / drug | Reaction type (ie rash, collapse etc) |
|  |  |
|  |  |
|  |  |

1. When was your last **Pap Smear**? …………………………………………………………
2. **Past Medical History**

|  |  |
| --- | --- |
| List of Medical Conditions | List of current medications *(please include contraceptive pill and analgesics)* |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Have you had any **previous hospitalisation or operations** (please circle) Yes No

If yes please give details:

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

1. Are you currently seeing any **specialist doctors**?

Please give details

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