CARNEGIE MEDICAL CENTRE – Medical Questionnaire

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

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	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						

2. **<u>Alcohol</u>** – 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

3. **<u>Smoking</u>** (please circle one)

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

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

   Non Smoker NEVER Smoked

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

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

5. When was your last **Pap Smear**? ……

6. **Past Medical History**

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

7. Have you had any **previous hospitalisation or operations** (please circle) Yes No
   If yes please give details:
   ……
   ……
   ……
   ……
   …….

8. Are you currently seeing any **specialist doctors**?
   Please give details
   ……
   ……
   ……
   ……
   …….