PATIENT QUESTIONNAIRE

Welcome to Murano Medical Centre, please take a few moments to fill in this questionnaire as fully as possible to enable us to give you the best care. Thank you.

First Name (S) ..... **Surname** .....

Date of Birth ..... **Marital Status** .... **Maiden Name** .....

Glasgow Address (Room, Flat and House No).....
Murano Student Village, Glasgow G20 7SB.

Mobile No..... **E-Mail address (if applicable)**.....

Name of Parents/Guardian ..... **Telephone No**.....

Home Address.....

Name and Address of previous Doctor.....

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Name of Course being taken ..... **How many years in Glasgow** .....

In the following questions, please delete YES or NO and supply further information as necessary.

Do you Smoke? YES **How many per day?** .....
NO **Have you ever smoked? No/Yes If Yes when did you stop?**.....

Height ..... Weight ..... **How much alcohol do you drink in a week?**.....

Blood Pressure ..... **(If unknown, our Dr or Nurse will measure this as required)**

Do you have any other regular treatments or medicines (Including Contraception) YES/NO

(If YES, please give details) .....

Any serious illnesses now or in the past? YES/NO (If yes, please give details) .....

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Any serious illnesses which run in your family? YES/NO (If YES, please give details).....

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Any Allergies? YES/NO e.g. Penicillin, nuts etc **(If YES, please give details)**.....

Any Immunisations in the past 5 years? (Please include all travel vaccinations) YES/NO (If YES, please give details)

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Ethnic Origin..... **Any other relevant information?**.....

FEMALE STUDENTS ONLY. Have you ever had a Cervical Smear YES/NO (If YES, continue below)

When ?..... **Where? (GP, Hospital, FPA)**.....**Result ? OK/ PROBLEM (details**

please).....

Signed .....**Date**..... **Date arrived in UK (if applicable)**.....