**New Patient Questionnaire**

**Your Details**

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Landline Telephone**  |  | **Mobile****Number** |  |
| **Height** |  | **Weight** |  |
| **Date of Birth** |  |
| **Marital Status** |  |
| **Occupation** |  |
| **Next of Kin & contact details****Relationship to patient** |  |
| **Are you a carer for someone? Please give details** |  |

Have you been registered with this practice before? Yes 🞏 No 🞏

***Please note if you have previously been removed from the practice list due to aggressive behaviour or failing to attend appointments you may not be re-registered.***

Main Language Spoken: English 🞏 Other 🞏 British Sign Language 🞏

If other, please specify:

Do you require an interpreter? Yes 🞏 No 🞏

**Ethnicity**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| White Scottish | 🞏 |  | Other white British group | 🞏 |
| White Irish | 🞏 |  | Other white ethnic group | 🞏 |
| Indian | 🞏 |  | Bangladeshi | 🞏 |
| Chinese | 🞏 |  | Other Asian ethnic group | 🞏 |
| Black African | 🞏 |  | Other black ethnicity | 🞏 |
| Other ethnic, mixed origin | 🞏 |  |  |  |

**Medical Problems**

Do you have any current medical problems? Yes 🞏 No 🞏

Please indicate which medical problems you have:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Asthma | 🞏 |  | Depression | 🞏 |  | Learning Disabilities | 🞏 |
| Atrial Fibrillation | 🞏 |  | Diabetes | 🞏 |  | Mental Health Problems | 🞏 |
| Cancer | 🞏 |  | Epilepsy | 🞏 |  | Osteoporosis | 🞏 |
| Heart Disease | 🞏 |  | Heart Failure | 🞏 |  | Peripheral Arterial Disease | 🞏 |
| COPD | 🞏 |  | Hypertension | 🞏 |  | Rheumatoid Arthritis | 🞏 |
| Dementia | 🞏 |  | Hypothyroidism | 🞏 |  | Stroke / TIA | 🞏 |

If you have any other conditions not indicated above, please give details in the space below:

|  |
| --- |
|  |

**Serious Illness and Surgical Procedures**

Have you ever had any serious or significant illnesses or surgical procedures?

If yes, please give details in the space below:

|  |  |
| --- | --- |
| **Date** | **Description of Illness or Surgical Procedure** |
|  |  |
|  |  |
|  |  |
|  |  |

**Medication**

Are you allergic to any medications? Yes 🞏 No 🞏

Are you allergic to any other substances? Yes 🞏 No 🞏

If you have any allergies, please provide details in the space below:

|  |
| --- |
|  |

Please provide details of any medication you are currently taking:

|  |
| --- |
|  |

**Vaccinations**

Your medical records may take some time to arrive in the Practice. If you are currently due any vaccinations please provide details in the space below:

|  |
| --- |
|  |

**Family History**

Please list any particular illnesses or diseases that run in your family in the box below. Please include details of heart disease in parents, brothers, and sisters and the approximate age at which it occurred.

|  |
| --- |
|  |

**Lifestyle Information**

**Smoking**

Please complete the following boxes:

|  |  |  |
| --- | --- | --- |
| Never Smoked 🞏Tobacco | Ex-Smoker 🞏Amount per day?When did you stop? | Current Smoker 🞏Amount per day? ***We advise all smokers to stop smoking. For advice see your GP or contact Fresh Airshire on******01292 885827.*** |

Do you use electronic cigarettes? Yes 🞏 No 🞏

**Alcohol**

**How many units of alcohol do you consume in a typical week?**

1 unit of alcohol is the equivalent of:

|  |  |
| --- | --- |
| * ½ pint of regular strength beer
 | * 1 small glass of white wine
 |
| * 1 alcopop
 | * 1 measure of whisky
 |

**Physical Activity**

How often do you exercise for more than 30 minutes?

 Five or more times a week 🞏

Three or Four times a week 🞏

Once a week 🞏

Less than once a week 🞏

Unable to exercise 🞏

**Drug Misuse**

Do you currently use illicit drugs? Yes 🞏 No 🞏

Have you used illicit drugs in the past? Yes 🞏 No 🞏

**Female Health Issues**

Have you had a cervical smear test? Yes 🞏 No 🞏

If yes, when was this last done?

Have you had a breast screening test? Yes 🞏 No 🞏

If yes, when was this last done?

Do you currently use contraception? Yes 🞏 No 🞏

If yes, what contraception do you use?

Are you currently pregnant? Yes 🞏 No 🞏

How many pregnancies have you had?

How many children do you have?

***Patient Signature:***

***Date:***

***FOR SURGERY USE ONLY***

|  |  |  |
| --- | --- | --- |
| No appointment required | 🞏 |  |
| GP appointment | 🞏 | Details: |
| Nurse appointment | 🞏 | Details:  |
| HCA appointment | 🞏 | Details: |
| Phlebotomy appointment | 🞏 | Details: |
| Admin | 🞏 | Details: |
|  |  |  |

Reviewed by:

Date: