Bishopton Medical Practice New Patient Questionnaire

EMIS NO.

Personal Details

Surname: ..... **First Name(s)** .....

Maiden Name:..... **Parent/Guardian Name:** .....

Date of Birth:..... **Date:**.....

Address: .....

.....

..... **Postcode:**.....

Home Telephone NO.:..... **Work Telephone NO.:** .....

Mobile Telephone NO.:..... **Email Address:**.....

Occupation: .....

Country of Origin:..... **Ethnic Group:**.....

Marital Status:.....

Next of Kin:..... **Next Of Kin Relationship:**.....

Next of Kin Address: .....

..... **Postcode:**.....

Next Kin Telephone NO.:.....

Previous Doctor Name and Address:.....

.....

.....

Please check the appropriate box if you *do/ do not wish* to receive information regarding appointment reminders & heath checks by SMS (any patients over 14 will need to give their own consent) **YES**☐ **NO**☐ **(If left blank you will be opted out)**

Medical Information

	NO	YES	
Do You Have a Carer?	☐	☐	(If Yes Please Provide Carers Name and Contact NO.:) .....
Are You a Carer?	☐	☐	(If Yes who for i.e. friend/mother etc:) .....

Do You Suffer From Any Of The Following Conditions:

Allergies Drug	☐	☐	(If Yes From What Drugs:) .....
Allergies Food	☐	☐	(If Yes From What Foods:).....
Angina	☐	☐	(If Yes From What Date/Year:) .....
Arthritis	☐	☐	(If Yes From What Date/Year:) .....
Asthma	☐	☐	(If Yes From What Date/Year:) .....
Anxiety/ Depression	☐	☐	(If Yes From What Date/Year:) .....
Bowel Disorder	☐	☐	(If Yes From What Date/Year:) .....
COPD	☐	☐	(If Yes From What Date/Year:) .....
Diabetes	☐	☐	(If Yes From What Date/Year and **Type 1 or 2**:).....
Eczema/ Dermatitis	☐	☐	(If Yes From What Date/Year:) .....
Epilepsy	☐	☐	(If Yes From What Date/Year:) .....
Hay Fever	☐	☐	(If Yes From What Date/Year:) .....
Heart Failure	☐	☐	(If Yes From What Date/Year:) .....
High Blood Pressure	☐	☐	(If Yes From What Date/Year:) .....
Mental Health Conditions	☐	☐	(If Yes From What Date/Year And Condition:) .....

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	NO	YES	
Psoriasis	☐	☐	(If Yes From What Date/Year:) .....
Thyroid Disease	☐	☐	(If Yes From What Date/Year:) .....

Please List Any Other Conditions That Are Not Mentioned: .....

.....

.....

General Information

Height ☐ **Feet & Inches or CM** **Weight** ☐ **Stones/KGs**

Smoking Status - Cigarette/Cigar/Pipe

	NO	YES	
Current Smoker	☐	☐	(If Yes From What Date/Year And Number Per Day:) .....
EX-Smoker	☐	☐	(If Yes From What Date/Year Stopped:).....
Never Smoked	☐	☐	

Alcohol Intake

	Wine	Beer	Spirits
Number Of Units Consumed Per Week	☐	☐	☐
	Small Glass = 1unit **Medium = 2 units** **Large = 3 units**	***1 Pint = 2 units***	***1 Measure (pub) = 1 unit*** **Home = 2 units**

Exercise

What type of exercise are you involved with: General☐ Running ☐ Swimming ☐ Aerobic ☐ Cycling☐ Other ☐

Other Than General How Many Times Per Week Do You Do This: 1☐ 2☐ 3☐ 4☐ 5+☐

Please List Any Medication You Are Currently Taking – ***(Alternatively please hand in your repeat slip from last practice)***

Name Of Drug	Dose /Strength	Reason
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Immunisation History

Do You Know The Date/Year You Received: Tetanus: ..... Any Other: .....

Family History

Have Any Of Your Blood Relations Suffered From: (*If Yes Please State the Relative And Age If Known*)

Heart Disease: ..... Diabetes ..... High Blood Pressure .....

Breast Cancer: ..... Bowel Cancer: ..... Stroke: .....

Other Serious Illness: .....

Female Patients Only

How many pregnancies have you had? .....

Do You Have Any Children **NO** ☐ **YES** ☐ (If Yes Please State the Number And Ages).....

Have You Had Any Miscarriages **NO** ☐ **YES** ☐ (If Yes Please State the Number) .....

Have You Had A Hysterectomy **NO** ☐ **YES** ☐ (If Yes Please State the Type and Year) .....

When Was Your Last Smear Test And Result: .....