CRAMOND MEDICAL PRACTICE

QUESTIONNAIRE FOR NEW PATIENTS

(**Please note**: it is important to be as accurate as possible when filling out this questionnaire)

Name _____ Date of Birth _____

Address (inc. flat number) ☐ Male ☐ Female

_____ Telephone: _____

_____ Marital Status: _____

_____

Postcode _____ Occupation: _____

Have you been registered here before? **Yes / No**

If you were previously registered with the Practice and have changed your Surname, please tell us your previous Surname (your details will be already stored on our computer). _____

Next of kin

Name _____

Address

_____

_____

_____

Telephone No. _____

Relationship to you _____

Other contact in emergency

Name _____

Address

_____

_____

_____

Telephone No. _____

Relationship to you _____

Are other members of your household registered/registering at the practice?

Name	*Date of Birth*

Please indicate your ethnic group

☐ White Scottish

☐ White British

☐ White Irish

Other white background (please state)

_____

☐ Black Caribbean

☐ Black African

Other Black background (please state)

_____

☐ Asian - Indian

☐ Asian - Pakistani

☐ Asian - Bangladeshi

☐ Chinese

Other Asian background (please state)

_____

☐ Mixed race

Any other ethnic group (please state)

_____

We can arrange an interpreter if you need one. Please state the language you require: _____

Medical Information
(If you are unsure about any answers please leave until you see the Doctor)

Current Medical Problems/Illnesses/Mental health issues

Serious Illnesses in the Past

Serious Illnesses	Date

Any Operations (if not mentioned above)?

Operations	Date

Do You Have Any Allergies?
(Please include drug allergies and non drug allergies e.g. penicillin, peanuts, bee sting, pollen etc)

Females Only

(Please note**: it is important to be as accurate as possible when filling out this questionnaire)**

Number of Pregnancies: _____

Names of Children	Dates of Birth

Are you pregnant at the moment: **Y / N** No. of weeks? Expected date of delivery**:**
Please Circle

Please give details of any miscarriage, termination or still birth:

Have you had a Hysterectomy: **Y / N** Date of Operation _____
Please Circle

Date of Last Smear: _____(Month & Year) Country where taken: _____

Smear Result: **Normal / Abnormal** When is your **next smear** due? _____
Please Circle

All Patients

Carers: Please indicate if you are an unpaid carer (i.e. you voluntarily provide continuing care for someone who could not manage without your help) (*Please Circle)* **Y / N**

What is the age of the person you care for? _____ What is their relationship to you? _____

What is their disability? _____

Regular Medication: Please give details of medication (including over the counter medication) that you have been taking on a regular basis, so that we can put this on our computer for your repeat prescriptions. **PLEASE ATTACH THE PRECRIPTIONS LIST FROM YOUR PREVIOUS DOCTOR**

Name of Drug	Dosage (if known)	Date Started

(Please circle or tick your answers)

DO YOU SMOKE? **NEVER**

YES PIPE / CIGARS / CIGARETTES

How many per day? _____

STOPPED

When? _____

DO YOU DRINK ALCOHOL? **YES**

How much alcohol do you drink weekly?

_____PINTS _____GLASSES WINE/SHERRY

NO

_____SHORTS (Gin, Vodka, etc.)

DO YOU EXERCISE? **YES**

How many days per week on average? _____

Is the activity:

NO LIGHT / MODERATE / HEAVY / ATHLETIC?

HEIGHT _____ **WEIGHT** _____

FAMILY HEALTH:

Are you aware of any hereditary diseases in your family?

Is there a strong family history of heart disease?

(Patient's Signature): _____

Date: _____

Please do not write below this line - for office use only

NEW PATIENT CHECK DATE:	REPEAT MEDICATION: NAME OF DRUG	STRENGTH	DAILY DOSE	QUANTITY
BP:				
URINALYSIS:				
	Review Date:	*Administration Completed:*		

ID confirmed				
		Specify which form of ID supplied	*Staff Initial*	*Date*