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 box if you do not wish to receive information regarding appointments & heath checks by SMS ☐

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:

	NO	YES	
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: ....