** NEW PATIENT QUESTIONNAIRE**

**Please complete in CAPITAL letters and tick the boxes**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name :** |  | **Surname** : | |  |
| **Date of Birth :** |  | | | |
| **Ethnic Origin :**  Bangladeshi Other ethnic origin  Black African Other mixed origin ethnic  Black British Other white ethnic  Black Caribbean Pakistan  Black, other White British  Chinese White Irish  Indian White Scottish  Other Asian | | | **Occupation:**  **Marital Status:**  **Mobile No:**  **Consent to send text message? Yes / no**  **Work contact no.:** | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Are you on any regular medication, including anything you buy over the counter?  **YES (list below) NO**      (continue on a separate sheet if necessary)   |  |  |  | | --- | --- | --- | | Drug Name | Strength | Directions (eg one twice daily) | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Have you provided a repeat prescription form from your previous surgery? Yes / no  Please circle which chemist you would like to collect your prescription  **Boots KinWell Ardersier Pharmacy Tornagrain** | |
| Have you had any operations/serious illnesses in the past ? | **YES NO** If yes, please give details with dates |

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|  | | **PREVIOUS MEDICAL HISTORY**  **Have there been any instances of :** | | | |
| **Condition** | |  | **Please circle if you have you any of the following?** | **Please circle if there is a family(parent, sibling or child) history of any of the following** | | |
| Asthma | |  | Yes No | Yes No | | |
| Cancer / Type | |  | Yes No | Yes No | | |
| Diabetes | |  | Yes No | Yes No | | |
| Epilepsy | |  | Yes No | Yes No | | |
| Heart Disease | |  | Yes No | Yes No | | |
| High Blood Pressure | |  | Yes No | Yes No | | |
| Stroke | |  | Yes No | Yes No | | |
| Any other (if yes please state) | |  |  |  | | |
| Do you have any Allergies YES NO If yes, what are they - | | | |
|  | | | |
| Do you have any drug related allergies YES NO If yes, what are they? | | | |
|  | | | |

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| --- | --- |
| Height……………………………. | Weight……………………. |

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| --- | --- | --- |
| **SMOKING – tick the answer which best applies** | | |
| Current smoker\* | Never smoked | Ex Smoker |
| *\*If you have ticked this box, we recommend you try to stop smoking. Did you know that you are more likely to quit if you see a smoking cessation adviser? Interested? Pick up a self referral from reception.*  If you are a **smoker**, how many do you currently smoke? ...............  If you are an **ex-smoker**, when did you quit?........... | | |

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|  |
| **Alcohol**  Do you drink alcohol? Yes No  If **YES** how many units per week? ....... units  (1 unit = ½ pint of beer or cider, 1 measure of spirit, ½ glass wine) | |

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| --- |
| **Do you need sign language support?**  Y / N    **Do you need an interpreter?**  Y / N    If yes, please state what language you speak \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **For female patients only** | Please state previous Cervical Smear date: | | | | |
| Contraception method used : | Pill | Coil | Implant | Injection | Sterilised |

**Further Information**

**Next of kin**

**Name…………………………. Date of Birth …………………………**

**Relationship………………… Home Town ………………………….. Tel No ………………………….**

**Are you a carer? Yes No**

**Are you cared for ? Yes No**

**Power of Attorney Held ? Yes No**

**If YES please provide details:**

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