** 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 ScottishOther 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 / noPlease 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 |

|  |  |
| --- | --- |
|  | **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? |
|  |

|  |  |
| --- | --- |
| 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 NoIf **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 / NIf 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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