Craigshill Health Centre
New Patient Medical Questionnaire

Thank you for your interest in Craigshill Health Centre. We hope you will find the information in the Practice Brochure helpful. You are invited to attend a brief registration medical examination and this will be organised by our reception staff at a mutually convenient date and time. Please remember to bring a specimen of urine with you when you come for your appointment.

PATIENT DETAILS:

First Name	
Surname	
Previous Surname	
Address and Postcode	
Home Telephone Number	
Mobile Number	
Date of Birth	
Marital Status	
Occupation	
Previous Address	
Name and Address of Previous GP	
If you were registered with us previously, please give date	
Next of Kin Details	

Please tick as appropriate:

Male ☐ Female ☐

Married ☐ Single ☐ Cohabitee/with Partner ☐ Divorced ☐ Separated ☐ Widow/Widower ☐

Ethnic Origin
The following questions follow the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. It is not compulsory to answer these questions, but it may help with your healthcare provisions as some health problems are more common in specific communities.

Please tick:

White
☐☐ British/Mixed British
☐ Scottish
☐ English
☐ Welsh
☐ Northern Irish
☐ Irish

Mixed
☐ White & Black Caribbean
☐ White & Black African
☐ White & Asian
☐ Other (please state):

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Malaysian
☐ Other Asian background (Please state) _____

Black or Black British
☐ Caribbean
☐ African
☐ Other black background
(please state): _____

Chinese or other Ethnic Group
☐ Chinese
☐ Other European origin (please state):

Other European origin (please state): _____

Do you need an Interpreter or Sign Language Support Yes ☐ No ☐
If you need an Interpreter, what language do you speak? _____
If you do not wish to give this information, please tick here ☐

Health Information
Please tick if you have, or if you ever have had, any of the following? Please give dates of diagnosis.

Asthma ☐ Other chest/lung disease (please specify) ☐ Epilepsy ☐ Diabetes ☐
Thyroid problems ☐ Depression ☐ Other Mental Health Problems ☐
Cancer ☐ Heart Disease ☐ High Blood Pressure ☐
Stroke ☐ Splenectomy ☐ Kidney Disease ☐
Angina ☐

Height: _____ **Weight**: _____

Any other serious illness, operations or disability? (please state):

_____

_____

Are you receiving treatment for any addiction? Yes ☐ No ☐ (please state) _____

Are there any illnesses which run in the family? Yes ☐ No ☐ (please state) _____

Has any close relative (mother, father brother or sister) had: **Who/Age**

A heart attack Yes ☐ No ☐ (please state) _____
A stroke? Yes ☐ No ☐ (please state) _____
Trouble with high cholesterol? Yes ☐ No ☐ (please state) _____
Diabetes? Yes ☐ No ☐ (please state) _____

Blood Tests
Do you need any regular blood tests? Yes ☐ No ☐
If yes, give details and date of last test. _____

Allergies
Do you have any known allergies to medicines or food? Yes ☐ No ☐
If yes, please specify: _____

Vaccinations
If you are over 20, please tick which vaccinations you have had and give approximate date(s):

Diphtheria ☐ Polio ☐ Measles ☐
Tetanus ☐ 2xMMR ☐ Whooping Cough ☐
Meningitis C ☐ Hepatitis B ☐ German Measles (Rubella) ☐

Smoking and Alcohol

Never smoked tobacco ☐ Ex-smoker ☐ Current smoker ☐ Number per day ☐

How many units of alcohol do you drink per week? ☐
(1 unit = 1 small glass of wine, or ½ pint of beer, or 1 pub measure of spirits)

If you feel you smoke or drink too much would you like help reducing or giving up? Yes ☐ No ☐
(Smoking cessation advice given **)**

Carers
Are you a Carer? Yes ☐ No ☐ If yes, who do you care for? _____
Are you a person being cared for? Yes ☐ No ☐

Female Patients Only
Have you had a hysterectomy? Yes ☐ No ☐
Have you ever had a cervical smear? Yes ☐ No ☐
If yes, please give date of last smear test ____/____/____ Normal ☐ Abnormal ☐
Are you pregnant or have you had a baby recently? Yes ☐ No ☐
If yes, please give details of date of delivery or expected date: ____/____/____
If you have ever been pregnant please give:
Number of births _____
Any other pregnancies (e.g. ectopics, miscarriages, terminations) _____

Please list any regular medication or other prescriptions you need. **Please continue on a separate sheet if necessary**

Medication	Dose (e.g. tablet size/quantity	Frequency of Dose

If you require medication, please make an appointment to discuss. Please bring medications with you to the appointment.

Patient/Doctor Agreement

Our Team in Craigshill Health Centre are committed to providing you with a first-class service. In return we would ask you to commit to the following code of conduct:

- Please use the appointment system reasonably and responsibly. Requests for urgent appointments should be reserved for genuinely urgent medical problems. If you no longer require or cannot attend an arranged appointment, please cancel it as soon as you can so it can be offered to another patient.
- Please avoid requesting unnecessary house calls. Whenever possible patients should attend the health centre (or out of hours service) unless this is impossible because of your medical condition. If possible, please make any request for a house call before 10.00 a.m.
- At all times be truthful and honest with the doctor and members of staff.
- Violent and abusive behaviour, whether physical or verbal, could result in you being removed from the Practice List. If you are in any way dissatisfied with the service you have received, please contact the practice manager who will provide you with details of our complaints procedure.

SIGNED _____ DATE _____