NEW PATIENT QUESTIONNAIRE

Name ..... Date of Birth .....

Address ..... Marital Status

Married ☐
Single ☐
Divorced ☐
Widowed ☐
Separated ☐

.....

.....

Telephone Number ..... E-Mail Address .....

Mobile Number

Occupation .....

Next of Kin contact details

Name .....

Address ..... Telephone Number .....

..... Contact Number (if different from above) .....

Are you a Carer? ☐ Main carer for someone else? ☐ Who for? .....

Which ethnic group do you belong to? – You are not obliged to complete this section

Please ✓ as appropriate

☐ White ☐ Chinese ☐ Indian ☐ Bangladeshi
☐ Pakistani ☐ Black-African ☐ Black Caribbean ☐ Other – please state .....
☐ I do not wish to give this information

Other members of household:-

Name	Age	Relationship
.....	.....	.....
.....	.....	.....

Medical History

Previous Serious Illnesses	Operations and dates
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

We are currently offering testing for Hepatitis B, C and HIV to all new patients. There are now effective treatments available for these infections, but you cannot benefit from this without the relevant diagnosis. It is estimated that 50% of people who have Hepatitis C, 25% of those infected with HIV and the majority of people who have Hepatitis B remain undiagnosed.

In Scotland, treatment for HIV and hepatitis is free whatever your immigration status. The Equality Act 2010 protects people living with HIV from discrimination at work in the UK.

PLEASE NOTE: All patients who are automatically offered TB Screening will be offered BBV Testing at their screening and will have no need to have it done in General Practice.

Please tick if you wish to have the blood test for HIV/Hepatitis B and C ☐

If you do wish to be tested, please ask our reception team for the BBV information sheet , complete and return to reception for an appointment to be arranged.

Have you had a tetanus booster in the past 10 years

How many times per week do you exercise for 20 minutes or more? .....

Current Height ..... **Current Weight** .....

ADDITIONAL INFORMATION REQUIRED – PLEASE SEE OVERLEAF

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Sharing Information with Others

Sometimes it is useful to share health information with the local hospitals or with GMED. Would it be acceptable for us to share information about you, just when it is absolutely necessary? **YES / NO**

Do you give consent for us to contact you via text messages on the mobile number that you provided? **YES / NO**

Any Known Drug Allergies

....

....

Present regular medication (please list name, strength and how often taken)

Name Strength How often taken

....

....

....

....

Family History

Is there anyone in your family who has had

Heart Disease	☐	Please give details	.....
Stroke	☐	Please give details	.....
Cancer	☐	Please give details	.....
Diabetes	☐	Please give details	.....
High Blood Pressure	☐	Please give details	.....
Asthma	☐	Please give details	.....
Tuberculosis	☐	Please give details	.....

Smoking Habits

Smoker ☐ Number of cigarettes/cigars per day .....

Stopping smoking can make a big difference to your health

Smoking Cessation advice is available from the GP, Practice Nurse or your Local Pharmacy

Non-Smoker ☐

Ex-Smoker ☐ Date Stopped ..... Number of cigarettes/cigars per day .....

Alcohol Intake

Please estimate your alcohol intake per week (1 unit = half pint beer or 1 glass wine or 1 measure spirit)

Number of units per week .....

Women Only								
Pregnancies (Year)	**1**		**2**		**3**		**4**	
Any Known Problems? – Please state								
Last Cervical Smear	When		Where		By Whom			

	Please Circle	
Are you taking the contraceptive pill?	**Y/N** Name of pill:	
Do you have an implant?	**Y/N** Date inserted:	by GP/Family Planning/ Hospital
Do you have an IUD?	**Y/N** Date inserted:	by GP/Family Planning/ Hospital
Are you using any other form of contraception?	**Y/N** Give details:	

Date Form Completed .....