CRAMOND MEDICAL PRACTICE

QUESTIONNAIRE FOR NEW PATIENTS

(**Please note**: it is important to be as accurate as possible when filling out this questionnaire)

Name ______________________

Address (inc. flat number)

____

____

____

Postcode ______________________

Date of Birth ______________________

☐ Male ☐ Female

Telephone: ______________________

Marital Status: ______________________

Occupation: ______________________

Have you been registered here before? **Yes** / **No**

If you were previously registered with the Practice and have changed your Surname, please tell us your previous Surname (your details will be already stored on our computer). ______________________

Next of kin

Name ______________________

Address

____

____

____

Telephone No. ______________________

Relationship to you ______________________

Other contact in emergency

Name ______________________

Address

____

____

____

Telephone No. ______________________

Relationship to you ______________________

Are other members of your household registered/registering at the practice?

Name	*Date of Birth*

Please indicate your ethnic group

☐ White Scottish

☐ White British

☐ White Irish

Other white background (please state)

____

☐ Black Caribbean

☐ Black African

Other Black background (please state)

____

☐ Asian - Indian

☐ Asian - Pakistani

☐ Asian - Bangladeshi

☐ Chinese

Other Asian background (please state)

____

☐ Mixed race

Any other ethnic group (please state)

____

We can arrange an interpreter if you need one. Please state the language you require:

Medical Information
(If you are unsure about any answers please leave until you see the Doctor)

Current Medical Problems/Illnesses/Mental health issues

Serious Illnesses in the Past

Serious Illnesses	Date

Any Operations (if not mentioned above)?

Operations	Date

Do You Have Any Allergies?
(Please include drug allergies and non drug allergies e.g. penicillin, peanuts, bee sting, pollen etc)

Females Only

(Please note: it is important to be as accurate as possible when filling out this questionnaire)

Number of Pregnancies: ___________

Names of Children	Dates of Birth

Are you pregnant at the moment: **Y** / **N** No. of weeks? Expected date of delivery**:**
Please Circle

Please give details of any miscarriage, termination or still birth:

Have you had a Hysterectomy: **Y** / **N** Date of Operation _____________
Please Circle

Date of Last Smear: ____________(Month & Year) Country where taken: _______________

Smear Result: **Normal** / **Abnormal** When is your **next smear** due? ____________
Please Circle

All Patients

Carers: Please indicate if you are an unpaid carer (i.e. you voluntarily provide continuing care for someone who could not manage without your help) (*Please Circle*) **Y** / **N**

What is the age of the person you care for? ______ What is their relationship to you? __________________

What is their disability? ____

Regular Medication: Please give details of medication (including over the counter medication) that you have been taking on a regular basis, so that we can put this on our computer for your repeat prescriptions. **PLEASE ATTACH THE PRECRIPTIONS LIST FROM YOUR PREVIOUS DOCTOR**

Name of Drug	Dosage (if known)	Date Started

(Please circle or tick your answers)

DO YOU SMOKE? **NEVER**

YES PIPE / CIGARS / CIGARETTES
How many per day? ________________

STOPPED When? ________________

DO YOU DRINK ALCOHOL? **YES** How much alcohol do you drink weekly?

________ PINTS ________ GLASSES WINE/SHERRY

NO ________ SHORTS (Gin, Vodka, etc.)

DO YOU EXERCISE? **YES** How many days per week on average? __________

Is the activity:
LIGHT / MODERATE / HEAVY / ATHLETIC?

NO

FAMILY HEALTH:
Are you aware of any hereditary diseases in your family?

Is there a strong family history of heart disease?

(Patient's Signature): ______________________________

Date: ______________________________

Please do not write below this line - for office use only

NEW PATIENT CHECK DATE:	REPEAT MEDICATION: NAME OF DRUG	STRENGTH	DAILY DOSE	QUANTITY
HEIGHT:				
WEIGHT:				
BP:				
URINALYSIS:				
	Review Date:	*Administration Completed:*		

ID confirmed				
		Specify which form of ID supplied	*Staff Initial*	*Date*