*1 Ashfield Road*

**NEW PATIENT MEDICAL QUESTIONNAIRE** Milngavie G62 6BT

*0141 956 1339*

Please complete the form and return to the surgery with your registration forms.

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| **1.0** **Personal Details** |
| Surname: | First Names: |
| Date of Birth: | NHS number: |
| Address:Post code: | Contact Details:

|  |  |
| --- | --- |
| *Tel Home* |  |
| *Tel Mobile* |  |
| *E-mail* |  |

 |
| Occupation: | Occupation of Partner: | No of dependents: |
| Ethnicity: | Marital Status: |
| **We use various systems to communicate with you regarding your appointments, general health reminders and to share practice information. This could be via text message, letter, email or phone. Please tick each box below to confirm you are happy for us to communicate with you:**Text Message: □ Email: □ Letter: □ Mobile Phone: □ Landline: □ |
| Next of kin details:*Name DOB**Address* *Contact Tel no. Mobile No.**Relationship to you:* Next of kin details:*Name* *Contact Tel no.**Relationship to you* |
| Do you look after any relatives not living with you? Yes / No |
| Are you are carer? Yes/No Do you have a carer? Yes/No |
| Have you ever lived abroad? Yes / No |

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| **2.0** **Medical History** |
| 2.1 Personal History |
| Have you ever suffered from any of the following conditions? (Please tick as appropriate)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Condition* | *Date of diagnosis* |  | *Condition* | *Date of diagnosis* |
| Asthma ( ) |  |  | Mental Health Problems ( ) |  |
| Diabetes ( ) |  |  | Cancer ( ) |  |
| Epilepsy ( ) |  |  | Blindness/ Glaucoma ( ) |  |
| Stroke ( ) |  |  | High Blood Pressure ( )  |  |
| Heart Attack/Angina ( ) |  |  | Raised Cholesterol ( ) |  |
| Thyroid Problems ( ) |  |  | Other: ( ) |  |

Please list operations, serious illness or disabilities:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Operation | Date |  | Illness | Date |  | Disability | Date |
|  |  |  |  |  |  |  |  |
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| *2.2 Family History* |
| Has any close relative (parent, brother or sister) suffered from: (Please tick as appropriate)

|  |  |  |
| --- | --- | --- |
| *Condition* |  | *Condition* |
| Heart Attack (Under 60) ( )Stroke ( )Diabetes ( )Asthma ( )  |  | High Blood Pressure ( ) Raised Cholesterol ( )Other ( ) |

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| *2.3 Medication and Allergies* |
| Are you currently taking any tablets, medicines or injections?

|  |  |  |
| --- | --- | --- |
| Name | Dosage | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

Do you have any known allergies to medicines or foods? Yes / No If 'Yes', please give details |
| **2.0** **cont’d** |
| 2.4 Immunisations and Vaccinations |
| *Children under 5 years*

|  |  |
| --- | --- |
| Vaccination | Date |
| 2 months: 1st Diphtheria/Tetanus/Polio/Meningitis/Whooping Cough |  |
| 3 months: 2nd Diphtheria/Tetanus/Polio/Meningitis/Whooping Cough |  |
| 4 months: 3rd Diphtheria/Tetanus/Polio/Meningitis/Whooping Cough |  |
| 12 months: HIB/MenC |  |
| 13-48 months: Meningitis (HIB) catch up (Booster) |  |
| 13 months: Measles, Mumps, Rubella (MMR) |  |
| 4 years: Pre School Booster (Dip/Tet/Pert/Polio) |  |
| 4 years: MMR Booster |  |
| Pneumococcal (PCV) |  |

*Adults*

|  |  |
| --- | --- |
| Vaccination | Date |
| Tetanus Course/booster in Last 10 years? |  |
| Polio booster in last 10 years? |  |
| Annual Flu vaccination? |  |
| Pneumococcal vaccination? |  |
| Other? Eg. Typhoid/Yellow Fever |  |

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| **3.0** **Lifestyle** |
| Please tick the appropriate answer**Smoking -** What is your current smoking status?

|  |  |
| --- | --- |
| Current smoker ( )Number per day .......... Do you wish to stop smoking? | Ex smoker ( ) When did you stop smoking? |
| ( ) Never smoked |

 **Drinking -** How many units of alcohol do you drink eack week?

|  |  |
| --- | --- |
| **1 unit = ½ pint beer = 1 spirit = 1 glass of wine**No of units ........... | Non Drinker ( ) |

**Diet -** How would you describe your diet?

|  |  |
| --- | --- |
| My diet is varied and balanced Yes / No | ( ) I am on a weight reducing diet |
| I am on a special diet for medical reasons. ( )Reason ...........................  | ( ) I am a Vegetarian / Vegan |

**Exercise -** How would you describe your current level of exercise?

|  |  |  |
| --- | --- | --- |
| ( ) None | ( ) Impossible | ( ) Light |
| ( ) Moderate | ( ) Strenuous | ( ) Athlete |

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| --- |
| **4.0** **Female Patient Only** |
| 4.1 *Cervical Smear* |
| Please tick or complete / delete appropriate sections

|  |  |
| --- | --- |
| Have you ever has a smear? | Yes / No |
| When did you last have a smear? |  |
| Was the result normal?If abnormal, please give details: | Yes / No |

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| 4.2 *Contraception* |
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|  |  |
| --- | --- |
| I currently / have previously taken contraceptive pills I started taking them in ................................ | Yes / No  |
| I currently have/ have previously had/ a coilThis was fitted/ removed in ........................................ |  Yes / No |

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| 4.3 *Pregnancies* |
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|  |  |
| --- | --- |
| I have had …… pregnancies, resulting in:Live births ……Still births …….Miscarriages ….. | Have you had any problems during pregnancy?Yes/NoIf ‘Yes’, please give details: |

 |
| 4.4 *Other* |
| Have you ever had a hysterectomy? Yes / No If ‘Yes”, date: …………………………………Have you ever had a mammogram? Yes / No If ‘Yes”, most recent date: ……………………. If 'Yes', please give details |

**THANK YOU FOR COMPLETING THIS FORM**