**NEW PATIENT QUESTIONNAIRE**

We would be grateful if you would complete this questionnaire in full. As a new patient to the Practice we advise you to make an appointment with a Practice Nurse for a Basic Health Check – our Reception staff will be happy to help you with this. This will also give you the opportunity to discuss any health needs you may have.

### Personal Details

|  |  |
| --- | --- |
| **Name:** | **Your Next of Kin or emergency contact details**  |
| **Date of Birth:** | **Name:-** |
| **Address:** | **Relation to you:-** |
| **Postcode:** | **Contact phone number for next of kin or emergency contact:-** |
| **Home Phone** |
| **Mobile phone no:** |  |

### Personal Profile \*delete as appropriate

|  |
| --- |
| What is your occupation? |
| Do you smoke? \*Smoker / Ex Smoker / Never Smoked |
| Do you drink alcohol? \*Yes / NoIf Yes – how many units per week? \_\_\_\_\_\_\_ units per week (unit = 1 glass wine/½ pint beer/1 measure spirit) |
| What regular exercise do you take? |
| Are you a carer? \*Yes / No | If Yes – who do you care for? |
| Do you have a carer? \*Yes / No | Please give their name and contact telephone number. |
| What is your ethnic status? \*White – Scottish / Irish / British / Other  \*Asian – Indian / Pakistani / Bangladeshi / Chinese  \*Black – African / Caribbean / Other  Other ethnic group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM

### Details of Family Illness - (Mother / Father / Brother / Sister / Children)

|  |  |  |
| --- | --- | --- |
| Relation to you | Name | Major illness / cause of death |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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## **Health History**

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| --- |
| Please record any significant past illnesses, accidents, operations or other hospital admissions including if possible relevant dates.  |
| Date: DD/MM/YYYY Details: |
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###### Medication

|  |
| --- |
| Please list all the medication you take. Include items you buy regularly from the Chemist. |
| Name:   | Dose: |  | Name:   | Dose: |
| Name:   | Dose: | Name:   | Dose: |
| Name:   | Dose: | Name:   | Dose: |
| Name:   | Dose: | Name:   | Dose: |
| Name:   | Dose: | Name:   | Dose: |
| Name:   | Dose: | Name:   | Dose: |

Allergies

|  |
| --- |
| Do you have any allergies? \*Yes/NoIf yes, what are you allergic to? |

Thank you for taking the time to complete this questionnaire.

Please return this completed form to Alyth Health Centre, New Alyth Road, Alyth, PH11 8EQ.