New Patient Questionaire

Alyth Health Centre - Patient registration - New Patient Questionaire form

we would be grateful if you would complete this questionaire in full. As a new patient to the Practice we advise you to make an appointment with the practice nurse for a basic health check. The reception team will be happy to help you with this. This will allow you the opportunity to discuss any health needs you may have.

Patient Details	**Please complete in Block Capitals**
Patient Forename	
Patient Surname	
Date of Birth	D D / M M / Y Y Y Y
Email address - This email address will be used by your practice to send notifications and reminders to you.	**Consent for Email** Y/N
Mobile Number	**Consent for Telephone** Y/N
Date	D D / M M / Y Y Y Y

Your Next of Kin or Emergency Contact Details / Parent or Guardian	
Forename	
Surname	
Date of Birth	D D / M M / Y Y Y Y
Relationship to You	
Mobile Number	**Consent for Telephone** Y/N

Personal Profile					
What is your Occupation?					
Do you hold a current Firearms Certificate?	Y/N	If Yes, When from	M M / Y Y Y Y		
Do You Smoke?	Smoker		Ex Smoker		Never Smoked
Do You Drink?	Y/N	If Yes - How many units per week?			
Do you have any Allergies?	Y/N	If Yes, What are you allergic to?			
What regular exercise do you take?					
Are you a carer?	Y/N	If Yes - who do you care for?			
Do you have a carer?	Y/N	If Yes - Please give their name and contact details below			
Forename					
Surname					
Mobile Number		**Consent for Telephone** Y/N			
What is your etnic status?		**If Other please state**			

White	Scottish		Irish		British		Welsh		Other		
Asian	Indian		Pakistani		Bangladeshi		Chinese			Other	
Black	African		Caribbean		Other						

Please turn over and complete the other side

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Medical History	**Please record any significant past illnesses, operations etc including if possible relevant dates**							
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y
Details		M	M	/	Y	Y	Y	Y

Medication	**Please list all medication you take including items regularly purchased from a chemist.**		
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	
Name		Doseage	

Family History	**Please record any significant illness which has affected an immediate family member (mother, father, brother, sister,child) e.g Diabetes, heart diesease etc**		
Name		**Relationship to you**	
Name		**Relationship to you**	
Name		**Relationship to you**	
Name		**Relationship to you**	
Name		**Relationship to you**	
Name		**Relationship to you**	

Thank you for taking the time to complete this questionaire.

Please return this completed from to Alyth Health centre, New Alyth Road, Alyth, PH11 8EQ