PRIVATE AND CONFIDENTIAL

Welcome to the Aviemore Medical Practice, thank you for completing this new patient questionnaire.

DATE:

PLEASE CIRCLE ONE OF THE FOLLOWING: Mr Mrs Miss Ms

MARITAL STATUS: SINGLE, MARRIED, PARTNER, DIVORCED, WIDOWED

PLEASE PRINT

SURNAME	**FIRST NAME**
SECOND NAME	**KNOWN AS**
PREVIOUS SURNAME	**DATE OF BIRTH**
CONTANCT DETAILS	
MOBILE	**LAND LINE**
WORK	**e Mail**

EMERGENCY CONTACT: NAME..

CONTACT TELEPHONE NUMBER: ....

RELATIONSHIP: ....

FOR NURSE OR HEALTH CARE ASSISTANT USE ONLY

DATE OF HEALTH CHECK				
HEIGHT	**WEIGHT**	**BMI**	**U/A**	**B/P**
IF CURRENTLY SMOKING HAS CESSATION ADVICE BEEN GIVEN				
YES	**NO**			

NAME OF NURSE/HCA ....

Please answer the following questions

ARE YOU ON ANY REPEAT MEDICATION? Please note that if you are on any repeat medication you will initially need to see a GP prior to the Repeat Prescribing system being set up for you.

MEDICATION NAME AND DOSE ..This includes any inhalers for Asthma, contraception

LIFESTYLE, please be as accurate as possible:
Circle one of the following:-

Never Smoked tobacco	Current Smoker	Recreational Drugs User	Ex Smoker

NO EXERCISE	SOME EXERCISE	3 OR MORE TIMES A WEEK

How much alcohol do you drink in a week: 1 unit = ½ pint of beer/lager, 1 measure of spirits or 1 glass of wine

When was your last Tetanus Booster?

Do you act as a Carer for somebody? (either paid or unpaid) **YES** **Caring For:...**

WOMEN ONLY

When was your last Smear	
What was the Result	
What form of contraception do you use?	
Have any close relatives had Breast Cancer?	

Are you immune to Rubella (German Measles)?	YES	NO	DON'T KNOW

ABOUT YOUR MEDICAL HISTORY

Please circle, give Dates of first Diagnosis and brief details of any of the following that you may have.

ASTHMA	
COPD	
EPILEPSY	
DIABETES	
HEART DISEASE	
HIGH BLOOD PRESSURE	
HYPOTHYRODISIM (under active thyroid)	
STROKE	
CANCER	
DEPRESSION	
OTHER MENTAL HEALTH PROBLEMS	
ALLERGIES	
Have you every had any operation or procedures	
Have you had any admissions to hospital not noted above	
Other significant medical problems	

FAMILY HISTORY, Please tell if your Parents, Brothers, Sisters have suffering from or have had the following: Please can you inform us of the age they were at when first diagnosed and any details of the diagnosis that you may know

Heart Disease	Diabetes	Stroke
High Blood Pressure	Epilepsy	Asthma

ETHNICITY

I DO NOT WANT TO STATE MY ETHNIC GROUP, PLEASE SIGN AND DATE
…………………………………………………………………………………………..

You must tick one box in this section

White Scottish	White English	White Welsh
White Northern Irish	White Irish	White British
White Gypsy/traveller	White Polish	Any other White ethnic Group
Other Ethnic Group		
Arab	Any other ethnic group	
Mixed or multiple ethnic groups		
Any mixed or multiple ethnic group		
Asian	Asian Scottish	Asian British
Indian	Indian Scottish	Indian British
Pakistani	Pakistani Scottish	Pakistani British
Bangladeshi	Bangladeshi Scottish	Bangladeshi British
Chinese	Chinese Scottish	Chinese British
Other Asian background		
African, Caribbean, Black		
African	African Scottish	African British
Caribbean	Caribbean Scottish	Caribbean British
Black	Black British	Black British
Other Black background		
Other Ethnic Group		
Arab	**Any other ethnic group**	

DO YOU HAVE ANY DISABILITIES (whether you are registered disabled or not)

Physical disability – please describe	
Sensory disability – please describe	
Learning disability – please describe	
Other – please describe	
No disability	
I DO NOT WISH TO ANSWER	

I need an interpreter		If so which language

I need sign language		If so which language

THANK YOU