Aviemore Medical Practice

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New Patient Health Check

Private and Confidential

Welcome to the Aviemore Medical Practice, thank you for completing this new patient questionnaire. Please fill in as many details as possible.

Date:					
Title (Mr, Mrs etc):					
Marital Status: (please circle)	Single	Married	Partner	Divorced	Widowed

Please Use Block Capitals

PERSONAL DETAILS:

Surname:	First Name:
Second Name:	Known As:
Previous Surname:	Date of Birth:
What is your Occupation?	Do you have any children, and if so, how many?

CONTACT DETAILS:

Mobile Number:	Home Number:
Work Number:	Email:
Emergency Contact Name:	Emergency Contact Number:
Emergency Contact's Relationship to You:	

OBSERVATIONS FOR NURSE OR HEALTH CARE ASSISTANT USE ONLY:

Date of Health Check:			
Height	**Weight**	**Urinalysis**	**Blood Pressure**

If currently smoking, has Cessation Advice been given?	Yes	No
Has Lifestyle Counselling Advice been given?	Yes	No
Name of Nurse/HCA		

Please answer the following questions using block capitals

MEDICATION:

REPEAT MEDICATION: ***Please note that if you are on any repeat medication you will initially need to see a GP before the Repeat Prescribing system can be set up for you.***
Medication Name and Dose:

LIFESTYLE:

Smoking Status (please circle):	Smoker	Ex Smoker	Never Smoked
	If smoking, how many per day?		

Exercise (please circle)								
In the past week, on how many days have you been physically active for a total of 30 minutes or more? *(Physical activity may include: walking or cycling for recreation or to get to and from places; gardening; and exercise or sport which lasts for at least 10 minutes)*	0	1	2	3	4	5	6	7
In four days or less, have you been physically active for at least two and a half hours (150 minutes) over the course of the past week?					No		Yes	
Are you interested in being more physically active?					No		Yes	

Alcohol (Number of measures consumed in a week)					
Wine		**Beer**		**Cider**	
Small glass		Pint		Pint	
Large glass		330ml		440ml	
Bottle		440ml		1 litre	
Spirits		**Alcopops**			
Single Measure		Small bottle (275 ml)			
Double Measure		Large bottle (700 ml)			
Bottle (700ml)					

Do you have a Carer?	Yes	No
Do you act as a Carer for somebody, paid or unpaid?	Yes	No

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?	

ABOUT YOUR MEDICAL HISTORY:

(Please give dates of first Diagnosis and brief details of any of the following that you may have.)

Asthma	
Allergies/Adverse Drug Reactions	
Cancer	
COPD	
Depression	
Diabetes	
Epilepsy	
Have you ever had any serious injuries such as broken bones, fractures or bad sprains?	
Have you ever had any operations or procedures?	
Have you had any admissions to hospital not noted above?	
Heart Disease	
High Blood Pressure	
Hypothyroidism (under active thyroid)	
Mental Health Problems	
Stroke	
Any other significant medical problems?	
Do you currently attend any hospital as an outpatient and, if so, for what?	

YOUR FAMILY HISTORY:

(Please tell us if your parents, brothers or sisters have suffered from or have had the following, please give us the age they were when first diagnosed and any details of the diagnosis that you know.)

Asthma	
Cancer	
Diabetes	
Epilepsy	
Heart Disease	
High Blood Pressure	
Stroke	

DO YOU HAVE ANY DISABILITIES:

(Please describe your disability, whether you are registered disabled or not.)

Learning Disability	
No Disability	
Physical Disability	
Sensory Disability	
No Disability	
I do not wish to answer	

ETHNICITY:

Although we are all individual people, our racial and ethnic backgrounds may place us at differing risks for some diseases. We are collecting race, ethnicity, and language information from **all of our patients** to help us get to know them better. By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your health needs. Your information is kept private and confidential and is protected by law. The only people who will see your information are members of your care team and others who are authorized to see your medical record.

Please choose one section, then tick one box that best describes your ethnic group or background.

I do not wish to state my Ethnic Group, please sign here: _____					
White Ethnic Group					
British		Irish		European	
Scottish		Other (*Please write in)		*	
Asian or Other Mixed Ethnic Group					
Bangladeshi		Indian			
Chinese		Pakistani			
Other (*Please write in)		*			
African, Caribbean or Black Ethnic Group					
African		Caribbean			
Black		Pakistani			
Other (*Please write in)		*			

INTERPRETATION:

Please let us know if you need any of the following:

Do you need an interpreter?	
If interpretation is needed, which language?	
Do you need sign language?	
If sign language, which language?	