Leith Mount Surgery - Patient Questionnaire *Confidential Form*

First Name _____ Address _____

Surname/Family Name _____ _____

Sex _____ _____

Date of Birth _____ Postcode _____

Marital Status _____ Telephone No _____

Occupation _____ Mobile No _____

Principal Language _____

Have you been registered here before? Yes/No

If "Yes" what was your name at that time?

Appointment Text Reminder Service

Put X in box to **OPT OUT** of this service ☐

Next of Kin _____ Relationship to you _____

Address _____ Tel. No. _____

_____

_____

Personal Medical History [please answer as fully as you can]

Do you suffer from any of the following illnesses? Please tick the appropriate answer.

Disease	Yes	No	*Date of diagnosis*	*Details*
Asthma	___	___	_____	_____
Eczema	___	___	_____	_____
COPD / Bronchitis	___	___	_____	_____
Heart Disease	___	___	_____	_____
Atrial Fibrillation	___	___	_____	_____
High Blood Pressure	___	___	_____	_____
Diabetes	___	___	_____	_____
Cancer	___	___	_____	_____
Epilepsy /Fits	___	___	_____	_____
Depression	___	___	_____	_____
Thyroid Condition	___	___	_____	_____
Schizophrenia	___	___	_____	_____
HIV / Hep B / Hep C (please circle)	___	___	_____	_____
Stroke	___	___	_____	_____
Chronic Kidney Disease	___	___	_____	_____
Learning Disability	___	___	_____	_____

Other important illnesses including any operations. Please give details below:

_____

_____

_____

_____

❋ PLEASE COMPLETE BOTH SIDES OF FORM ❋

If any of your family /close relatives suffered from any of the diseases above, please give details.

_____

_____

_____

Height _____ Weight _____ BP _____ Are you on Aspirin? _____

Please check if you are eligible for the Flu Vac. It could save your life.

Please list all the medicines you take or **attach the list from your previous Doctor.**
Please list diagnosis if known. (If child please also list vaccinations had and dates)

Medication / Child Vaccs.	Strength/Dose	Number times/day	Diagnosis / Date of Vacc. (child)

[If you are on a prescription for methadone, dihydrocodeine, or diazepam for addiction problems, please see reception for further details]

Are you Allergic to any medicines.[please list] _____
Are you Allergic to eggs. Yes No
Have you ever had a reaction to a vaccination. Yes No
[Please give details]_____

Some Questions about your lifestyle [please tick and give details where asked]

Smoking	**Alcohol**
Never ____	Never ____
Ex smoker ____ Date of stopping _____	Yes - How much per week
Current ____ How many per day _____	Shorts ____ Pints ____ Wine ____
	Used to drink heavily but not now :
	Total now _____
If you would like to stop smoking please ask at Reception to put your name down for our smoking cessation clinic.	**If you think you may have a problem with alcohol and would like help, please make an appointment with a doctor**

Drug use Never _____ Previously [but not now] _____
Yes _____ What do you take _____

Females Only
Last Smear Test : Date _____ Normal/Abnormal When next due _____
Where smear taken _____
How many children _____ Ages _____
Hysterectomy [reason if known] _____
Any miscarriages/still births/terminations [give details]_____
Current methods of Contraception _____

Please indicate your ethnic group

☐ White Scottish	☐ White British	☐ White Irish	Other white background (please state)
☐ Asian - Indian	☐ Asian - Pakistani	☐ Asian - Bangladeshi	Other Asian background (please state)
☐ Chinese	☐ Black African	☐ Black Caribbean	Other Black background (please state)
☐ Mixed Race			Any other ethnic group(please state)

** PLEASE COMPLETE BOTH SIDES OF FORM **

Child Health & Wellbeing
In order to help us identify children who may benefit from extra support

Is your child on the child protection register?	
Has your child previously been on the child protection register?	
Does anyone living in your household use non prescribed drugs?	
Does anyone living in your household have a regular prescription for methadone or diazepam?	
Does anyone living in your household drink alcohol to excess?	

Signed _____ Date _____