Leith Mount Surgery

Confidential Form

QUESTIONNAIRE FOR NEW PATIENTS

(**Please note**: it is important to be as accurate as possible when filling out this questionnaire)

Title: _____

Name: _____

Address: (inc. flat number)

_____

_____

Postcode: _____

Date of Birth: _____

Gender: _____

Telephone: _____

Relationship Status: _____

Occupation: _____

Have you been registered here before? **Yes / No**

If you were previously registered with the Practice and have changed your surname, please tell us your previous surname (your details will be already stored on our system). _____

Next of kin

Name _____

Address

_____

_____

Telephone No. _____

Relationship to you _____

Appointment Text Reminder Service:
Do you wish to receive text reminders for appointments and clinics at the surgery? **YES / NO**

Please indicate your ethnic group and country of birth: _____

☐ White Scottish

☐ White British

☐ White Irish

Other white background (please state)

_____

☐ Black Caribbean

☐ Black African

Other Black background (please state)

_____

☐ Asian - Indian

☐ Asian - Pakistani

☐ Asian - Bangladeshi

☐ Chinese

Other Asian background (please state)

_____

☐ Mixed race

Any other ethnic group (please state)

_____

We can arrange an interpreter if you need one.

Please state the language you require: _____

Do you have problems reading and writing in English: YES / NO

Do you require a sign language interpreter: YES / NO

Medical Information

Current Medical Problems/Illnesses/Mental health issues (please supply dates)

Serious Illnesses in the Past

Serious Illnesses	Date

Any Operations (if not mentioned above)?

Operations	Date

Do You Have Any Allergies?
(Please include **drug allergies** and **non drug allergies** e.g. penicillin, peanuts, eggs, bee sting, pollen etc)

Have you had a reaction to a vaccination?

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

FAMILY HEALTH:
Are you aware of any hereditary diseases in your family?

CARERS:
Please indicate if you are an unpaid carer (i.e. you voluntarily provide continuing care for someone who could not manage without your help) (*Please Circle)* **Y / N**

What is the age of the person you care for? _____ What is their relationship to you? _____

What is their disability? _____

Regular Medication: Please give details of medication that you have been taking on a regular basis, so that we can put this on our computer for your repeat prescriptions. **PLEASE ATTACH THE PRECRIPTIONS LIST FROM YOUR PREVIOUS DOCTOR**

Name of Drug	Dosage (if known)	Date Started

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

Are you on a prescription for methadone, dihydrocodeine, or diazepam for addiction problems?

If Yes please state which drug(s): _____

(Please circle or tick your answers)

DO YOU SMOKE? **NEVER**

YES PIPE / CIGARS / CIGARETTES
How many per day? _____

STOPPED When? _____

DO YOU DRINK ALCOHOL? **YES** How much alcohol do you drink weekly?

NO _____PINTS _____GLASSES WINE/SHERRY

_____SHORTS (Gin, Vodka, etc.)

HEIGHT _____ **WEIGHT** _____

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?	

Females Only

Number of Children: _____

Are you pregnant at the moment: **Y / N** No of weeks? ____ Expected date of delivery**:** _____
Please Circle

Please give details of any miscarriage, termination or still birth: _____

Have you had a Hysterectomy: **Y / N** Date of Operation _____
Please Circle

Date of Last Smear: _____(Month & Year) Country where taken: _____

Smear Result: **Normal / Abnormal** When is your **next smear** due? _____
Please Circle

ALL PATIENTS

Please sign and date below:

Signed _____ Date _____