Strathpeffer Medical Practice **Appointment time/date_____**

NEW PATIENT QUESTIONNAIRE

Please do not write in the grey boxes

Title: Mr/Master/Mrs/Ms/Miss/Other …….. Name: …….

Address: ……....Post code: ……

D.O.B./CHI ……. Tel. No: ……..

Date Questionnaire completed ……

Admin use only

1) Do you, or have you ever suffered from any of the following?

Asthma	YES/NO
Chronic Obstructive Pulmonary Disease (COPD) – Lung disease	YES/NO
Stroke	YES/NO
Thyroid disease	YES/NO
Epilepsy	YES/NO
Diabetes	YES/NO
Hypertension	YES/NO
Heart disease/Myocardial Infarction –Heart Attack	YES/NO
Mental Health Problems eg, depression, anxiety	YES/NO
Cancer	YES/NO
Chronic Liver disease	YES/NO
Chronic Kidney disease	YES/NO
Severe Learning Difficulties	YES/NO
Any other conditions or significant medical information	YES/NO

2) If the answer to any of the above is YES, please give details (including dates where relevant)

……...

……

3) Do you take any medication either regularly or intermittently relating to any of the above?

YES/NO

4) If the answer to Q3 is YES, please give details: ……

……

5) Do you take any other medication on a regular basis? YES/NO

6) If so, please give details ……..

7) Do you suffer any allergies? YES/NO

8) If yes, please give details ……

……

9) Smoking – please tick relevant box:

Never smoked ☐

Stopped smoking ☐ how long ago? …….

Current smoker ☐ how many Cigarettes/cigar/pipe per day? …..

Would you be interested in smoking cessation YES/NO

10) Alcohol – please tick relevant box:

Lifelong Teetotaller ☐

Current non-drinker ☐ how long? …….

Current drinker Rarely ☐ Occasional ☐ Moderate ☐ Heavy ☐

How often do you have eight (men) or six (women) or more units on one occasion?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

11) Exercise – do you regularly take exercise? Please give details:

No – physically impossible / No – avoid even trivial exercise ☐

Enjoy light exercise ☐

Details ……..Times per week ……..

Enjoy moderate exercise ☐

Details ……..Times per week ……..

Enjoy heavy exercise ☐

Details ……..Times per week ……..

Competitive athlete ☐

Details ……

12) Influenza vaccine:

Are you eligible for a 'flu vaccination? YES/NO

If YES, do you receive one annually? YES/NO

Reason for eligibility: over 65 years ☐

'at risk' group ☐ ……

14) Eyes:

Are you aware of the importance of regular eye checks? YES/NO

Do you have a family history of glaucoma? YES/NO

If so, please give details ……

15) Female Health:

How many pregnancies have you had? ……..

Are you currently pregnant? YES/NO

Are you taking the contraceptive pill? YES/NO

If yes, how long have you been taking it for? …….

Do you have a contraceptive coil fitted? YES/NO

If yes, when was it fitted? …….

Have you ever had a cervical smear test? YES/NO

If yes, when was the last one taken? ……..

Have you had a total hysterectomy? YES/NO

If yes, when? …….

16) Male health (only if over 65)

Have you ever had abdominal ultra-sound screening performed for early detection of abdominal aortic aneurysm?

If not, would you like to be referred? YES/NO

Highland region has offered this to all men for some years, but if you have moved into the Highland area from another Health Board you may not have been able to access this service.

17) Child Health (only complete if under 18 years)

Have you been immunised against any of the following (if so, please give dates where known)

Diptheria YES/NO ……
Tetanus YES/NO ……
Whooping cough YES/NO ……
Polio YES/NO ……
MMR YES/NO ……
Hib. (Meningitis) YES/NO ……

18) Family history:

Do you have a **close** family history (parents or siblings)of any of the following? If so, please give details and age at death, if relevant:

Hypertension (High blood pressure) YES/NO
Stroke/CVA YES/NO
Heart attack/Myocardial Infarction/Heart disease YES/NO
Diabetes YES/NO
Cancer (including site of disease) YES/NO

Details of any of the above:

……

……

19) Carers: (*A carer is a person who, without payment, provides help and support to a partner, child, relative, friend or neighbour who could not manage without their help)*

Do you have a carer? YES/NO
If YES, do you mind giving us their name and contact number? …….
……
Are you a carer for someone else? YES/NO

20) Yourself:

What is your current **Occupation:** ……

What is your **ethnic origin**? ……

What is your preferred **Pharmacy** for your prescriptions if required?.....

Do you consent to your medical information been passed to other Health Care agency's in event of an emergency? i.e. Ambulance or Hospital. **YES/NO**

B.P. ……..

Height ……. **Weight** …….

Appointments made	Date NPM done	Interview carried out by:

Thank you for taking the time to complete this questionnaire. A background knowledge of your medical history can be of considerable benefit to us, particularly until your medical records arrive from your previous G.P.

Strathpeffer Medical Practice Patient consent for text messaging communication

I choose to make use of the mobile telephone text messaging communication service with Strathpeffer Medical Practice. I confirm that I understand how this text messaging service communication works and the type of communication that can take place via text message. I confirm it is my responsibility to inform the Practice if my mobile number changes. I understand that text messaging is not a secure medium. I understand that there is a possibility that my text messages and the responses could be intercepted and read by someone else. I will bear this in mind in deciding how much information to seek and how much information to disclose by text message. I understand that if I require urgent clinical advice or attention I should contact my GP.

My mobile telephone number for text message communication is:

_____

My name: _____

My date of birth:_____

Patient's signature: _____Date: _ _ / _ _ / _ _ _ _

On behalf of Strathpeffer Medical Practice

Name: _____ Date: _____

Position: _____ Signature: _____

Consent - #9NdP
Decline - #9NdQ