Ayrshire Medical Group

New Patient Questionnaire

Please answer all questions as fully as possible and return your form to the GP Reception Desk. If there is not enough room on the form for your needs, please add comments on a separate sheet. **Please let the receptionist know if you require any help filling this form in.*

****Please note that it is the Practice policy that no one can be registered and therefore receive full services from this Practice until a completed questionnaire has been handed in.***

Date:……..

Preferred Title (Please circle): Miss Ms Mrs Mr

Surname……Forename…….

Date of birth……Male or Female……

Address……

……

. ……...

Postcode…… Ethnicity (i.e. white Scottish)……...

Telephone Landline Number…….....

Mobile Number…….

Next of kin and a contact number……...

Relevant Family History: Please tick relevant statements

Heart Disease:	**No Family history of heart disease** **History of heart disease under 60 years** **History of heart disease over 60 years** **History of Heart Attacks**
Diabetes:	**No Family History of diabetes** **Family History of diabetes** **Family History of diabetes in 1st degree relative (e.g.Parents, brothers,sisters)**

About Your Health

1. **Do you currently suffer from any of the following? (Please circle Yes or No). Please give an approximate date of diagnosis**

			Date
Alcoholism	**No**	**Yes**	
Asthma	**No**	**Yes**	
Cancer	**No**	**Yes**	
Diabetes	**No**	**Yes**	
Drug Dependency	**No**	**Yes**	
DVT	**No**	**Yes**	
Epilepsy	**No**	**Yes**	
Heart Disease	**No**	**Yes**	
Hepatitis	**No**	**Yes**	
High Blood Pressure	**No**	**Yes**	
Lung Disease (COAD/COPD)	**No**	**Yes**	
Mental Health Problems	**No**	**Yes**	
Rheumatoid Arthritis	**No**	**Yes**	
Stroke	**No**	**Yes**	
Thyroid Problems	**No**	**Yes**	

Have you had any operations? If yes Please give an approximate date and nature of operation.

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Have you or do you attend a hospital for any reason? If yes, please give details below.

……

……

……

Medication: Please include prescribed medication and over the counter medication

Name of Drug	What is it For?	Dose in mgs/mls	How many Tablets /When/How Often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Do you have any Drug Allergies? If YES, please list below

……

……..

Other Allergies? If YES, please list below

……..

……..

Please tell us your height- either Ft/inches…….. Or Metres……..

Please tell us your weight-either stones/pounds……. Or Kilos……

Smoking-please tick

Current Smoker: If YES, how many per day?.....

Ex-smoker: When did you stop?.....

Never Smoked:

Alcohol Consumption

(Approx 1 pint of beer is 2 units, a large glass of wine is 2 units, a double “short” is 2 units)

Number of units of alcohol consumed per week:

…….

Do you exercise regularly? YES…… No…….

If yes how do you exercise? e.g. walking……

Do you regularly care for a relative?..... If YES, would you like information on supports and services for carers?

……

Would you like to be registered as an organ donor……..

Have you had any immunizations recently? ……..

NHS Organ Donation Register: Have you completed this part of the registration form? YES/NO
Would you like any further information regarding NHS Organ Donation? YES/No

Questions for Female Patients

Current Contraception:…….....

Date of Last Smear:……

Date of Last Breast Screening:……..

How many pregnancies have you had:……

Children. If over 5yrs please name school attended

Name	DOB	
1.		School:
2.		School:
3.		School:
4.		School:

Office Use Only:- Urinalysis: