ASHGROVE GROUP PRACTICE

QUESTIONNAIRE FOR NEW PATIENTS

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

Name ____________________

Address (inc. flat number)

____

____

____

Postcode ____________________

Date of Birth ____________________

☐ Male ☐ Female

Telephone: ____________________

Marital 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 computer). ____________________

Next of kin

Name ____________________

Address

____

____

____

Telephone No. ____________________

Relationship to you ____________________

Other contact in emergency

Name ____________________

Address

____

____

____

Telephone No. ____________________

Relationship to you ____________________

Are other members of your household registered/registering at the practice?

Name	*Date of Birth*

Please indicate your ethnic group

☐ 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: ____________________

Medical Information
(If you are unsure about any answers please leave until you see the Doctor)

Current Medical Problems/Illnesses/Mental health issues – *please give details below*:

____
____
____
____
____

Serious Illnesses in the Past

Serious Illnesses	Date

Any Operations (if not mentioned above)?

Operations	Date

Do You Have Any Allergies? *Please circle*: YES NO
(Please include drug allergies and non drug allergies e.g. penicillin, peanuts, bee sting, pollen etc)

Details:____
____
____
____

Females Only

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

Number of Pregnancies: ___________

Names of Children	Dates of Birth

Are you pregnant at the moment: *please circle* **Y / N**
No. of weeks? __________ Expected date of delivery**:** ____________

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

Have you had a Hysterectomy: *please circle* **Y / N** Date of Operation _____________

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

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

All Patients

Regular Medication: Please give details of medication (including over the counter medication) that you have been taking on a regular basis, so that we can put this on our computer for your repeat prescriptions.

Name of Drug	**Dosage (if known)**	**Date Started**

(Please circle or tick your answers)

DO YOU SMOKE? | **NEVER** / **YES** / **STOPPED**

PIPE / CIGARS / CIGARETTES

How many per day? _______________

When? _______________

DO YOU DRINK ALCOHOL? | **YES** / **NO**

How much alcohol do you drink weekly?

________ PINTS ________ GLASSES WINE/SHERRY

________ SHORTS (Gin, Vodka, etc.)

DO YOU EXERCISE? | **YES** / **NO**

How many days per week on average? _________

Is the activity: LIGHT / MODERATE / HEAVY / ATHLETIC?

What is your current weight? ________________ What height are you? ____________________

Do you follow a particular diet? *(please circle)* YES NO *if yes please tick appropriate box below*

Low Fat Diet [ ] Plenty Fruit & Veg [ ] Special diet [ ]
Details:______________________
____

FAMILY HEALTH:

Please answer the following questions regarding your family history by circling either YES or NO -

Is there any history of your parents or brothers/sisters with any of the following?

Stroke before the age of 60	YES / NO	High Blood Pressure	YES / NO
Angina before the age of 60	YES / NO	Cancer	YES / NO
Diabetes	YES/ NO	Asthma	YES / NO

Patient Signature:_________________________

Date: __________________________

The following two pages contain details for carers/patients who have carers and patients who are blind or partially sighted.

Carers of West Lothian

A carer is an unpaid person who looks after a family member, friend or neighbour who is elderly, disabled or ill and needs help to live at home.

Carers of West Lothian provides information and support to carers caring for a family member or friend to help with the many difficulties and issues experienced by carers.

The service is provided free of charge and includes:

- Information
- One to one emotional support
- Home visits
- Signposting and referral to appropriate support services
- Financial, legal and carers' rights advice
- Hospital based support service for carers
- Dementia specific carer support service
- Access to advocacy
- Access to counselling
- Training courses for carers
- Breaks from caring
- Carer support groups

I would like Carers of West Lothian to contact me:

Name...

Address...

....

Postcode..

Telephone number...

Date of birth..

Name of person you care for...

Date of birth..

Health condition..

Relationship to carer..

You can return this freepost (no stamp required) to:
Freepost RTJJ-KRJG-HURG, Carers of West Lothian, Sycamore house, Quarrywood Court, LIVINGSTON, EH54 6AX
Tel: 01506 448000
office@carers-westlothian.com www.carers-westlothian.com

ARE YOU BLIND OR PARTIALLY SIGHTED?

YES [ ]
NO [ ]

IF YES PLEASE CONTACT THE SENSORY RESOURCES CENTRE

01506 774490

TO ENSURE YOU ARE ON THE REGISTER