The Aultbea & Gairloch Medical Practice

Dr G A Mitchell ¤ Dr G P Baptist ¤ Dr K M Vickerstaff ¤ Dr J W Ramsay

Date Form Completed:	

Please complete as much of this form as possible.
If particular questions do not apply to you, please ignore them.
It often takes several weeks for your records to reach us from your previous doctor. Answering these questions will help us care for you in the meantime. All information provided will be treated in line with the practice confidentiality policy (see practice leaflet for details).

NEW PATIENT HEALTH QUESTIONNAIRE

TITLE:		**FIRST NAME:**			
SURNAME:					
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)		
MARITAL STATUS:					
ADDRESS (incl flat no):		**WHO ELSE LIVES IN THIS HOUSEHOLD?**			
		ARE YOU A CARER FOR SOMEONE? **If yes, please specify:**	**YES** ☐ **NO** ☐ (please tick)		
HOME TEL:		**WORK TEL:**		**MOBILE TEL:**	
EMAIL ADDRESS:					
NEXT OF KIN: (Name, Address, Tel No.)					
ARE YOU HAPPY TO HAVE MESSAGES LEFT ON THE FOLLOWING NUMBERS?	**HOME TEL:**	**YES** ☐ **NO** ☐ (please tick)			
	MOBILE TEL	**YES** ☐ **NO** ☐ (please tick)			
OCCUPATION:					
ARE YOU CURRENTLY A STUDENT?	**YES** ☐ **NO** ☐	**IF YES, WHERE?**			
HAVE YOU BEEN A MEMBER OF THE UK ARMED FORCES FOR AT LEAST ONE DAY?	**YES** ☐ **NO** ☐	**IF YES, SERVICE NO:**			
		DATE STARTED:			

SMOKING HABIT					
Current Smoker		**Ex Smoker**		**Never Smoked**	
No. Cigarettes per day?		**Have you ever smoked?** Please tick		**I have never smoked** Please tick	
No. Cigars per day?		**If yes, what year did you stop?**			
Pipe tobacco per week? (oz / grams)		**How many *did* you smoke per day?**			
Would you like help to stop?	**YES** ☐ **NO** ☐				

ALCOHOL INTAKE	
Do you drink alcohol?	**YES** ☐ **NO** ☐ (please tick)
If Yes: Wines / Spirits: units per week	
Beer: units per week	
TOTAL units per week	
1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer	

EXERCISE HABIT	
Do you take regular exercise?	**YES** ☐ **NO** ☐ (please tick)
If Yes: What sort : (eg. Tennis, walking)?	
For how long at any one time?	
How many times weekly?	

MEDICATION	
ARE YOU ON ANY REGULAR MEDICATION? (including the contraceptive pill)	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state name and dose: (Ideally if you have a prescription reorder form from your previous doctor, please let us have a copy)	
ARE YOU ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please tell us the name of the medicine and the nature & severity of the reaction:	

WOMEN ONLY					
Date of Last Smear?		**What was the Result?**		**Where was it taken?**	
No. of Pregnancies?		**No. of Children?**		**Are you pregnant now?**	
Are you currently using a method of contraception?			**YES ☐ NO ☐**		
If YES, what method are you using?					

FAMILY HISTORY

Has a close relative (parent or sibling) suffered from any of the following conditions?
(please tick)

Stroke	**YES ☐ NO ☐**	**Who?**		**At what age?**	
Heart Disease	**YES ☐ NO ☐**	**Who?**		**At what age?**	
Diabetes	**YES ☐ NO ☐**	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ NO ☐
If Yes, Please give details:

OTHER INFORMATION

Is there anything else you feel we should be aware of?