BRUNTSFIELD MEDICAL PRACTICE

11 Forbes Road, Edinburgh, EH10 4EY

In order to be fully registered with this practice, this form MUST be completed and signed

NEW PATIENT HEALTH QUESTIONNAIRE (FOR ADULTS 16 YEARS +)					
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 CONTACTS?	HOME TEL:	YES ☐ NO ☐ (please tick)			
	MOBILE TEL	YES ☐ NO ☐ (please tick)			
	EMAIL ADDRESS:	YES ☐ NO ☐ (please tick)			
Do you consent to allow the Practice to text you non-clinical information and reminders to your mobile number:		YES ☐ NO ☐ (please tick)			
OCCUPATION:					
ARE YOU CURRENTLY A STUDENT?	YES ☐ NO ☐	IF YES, WHERE?			

SMOKING HABIT			
Are you a current smoker?		YES ☐ NO ☐ (please tick)	
IF YES:		IF NO:	
No. Cigarettes per day?		Have you ever smoked?	
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	
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: *******(Please note that you need to see a GP, if on existing medication, for a first repeat prescription to be issued. Make an appointment with a GP for a review of your medication in good time and before you run out!)*******	
ARE YOU ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state type and name:	

WOMEN ONLY					
Date of Last Smear?		**What was the Result?**		**Where was it taken?**	
No. of Pregnancies?		**No. of Children?**		**Are you pregnant now?**	

MEASUREMENTS & READINGS			
If known, can you give us up-to-date details for the following:			
Height:	(please specify units)	**Weight:**	(please specify units)
Blood Pressure:			

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) :

Condition	Response	Condition	Response
High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐ **Date:**
If Asthmatic, have you used your inhaler in past 12 months?	**YES** ☐ **NO** ☐ **Date:**		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had :

Details	Date
	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY

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

Condition	Response				
Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
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:

Please give details of the current state of your family's health:

	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Sibling(s)				

I have read and understood this form, and completed it honestly and to the best of my knowledge:

Name (print):		Date:	
Signature:			

Details of the person who completed the form, if different from above:

Name (print):		Date:	
Signature:			
Relationship to patient:			

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the practice

NAME ______________________________ **DOB** ______________

What is your main language? [ ]

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
Scottish	
English	
Welsh	
Northern Irish	
British	
Irish	
Gypsy/Traveller	
Polish	
Any other white ethnic group, please specify below:	

C. Asian, Asian Scottish, or Asian British	
Pakistani, Pakistani Scottish, or Pakistani British	
Indian, Indian Scottish or Indian British	
Bangladeshi, Bangladeshi Scottish, or Bangladeshi British	
Chinese, Chinese Scottish, or Chinese British	
Other Asian, please specify:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

D. African	
African, African Scottish, or African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean Scottish, or Caribbean British	
Black, Black Scottish, Black British	
Other Caribbean or Black, please specify:	

F. Other ethnic group	
Arab	
Other, please specify:	

If you would prefer not to provide this information, please tick here:	
If you don't know your ethnicity, please tick here:	