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**

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| **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?** | | | | | |  | |

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| 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** | | |

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| **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 | |

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| **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?** |  |

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| **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:** | |

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

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| **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:** | |  | | | | |

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| MEDICAL HISTORY | | | | |
| **Do you have/have you had any of the following conditions?** (please tick) **:** | | | | |
| **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 :** | | | | |
|  | | | **Date:** | |
|  | | | **Date:** | |
|  | | | **Date:** | |
|  | | | **Date:** | |

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

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| **Name (print):** |  | **Date:** |  |
| **Signature:** |  | | |

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

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

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

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| **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** | |  | **B. Mixed or multiple ethnic groups** | | |
| Scottish |  |  | Any mixed or multiple ethnic group |  | |
| English |  |  |  |  | |
| Welsh |  |  | **D. African** | | |
| Northern Irish |  |  | African, African Scottish, or African British |  | |
| British |  |  | **Other African, please specify:** | | |
| Irish |  |  |  | | |
| Gypsy/Traveller |  |  |  | | |
| Polish |  |  | **E. Caribbean or Black** | | |
| **Any other white ethnic group, please specify below:** | |  | Caribbean, Caribbean Scottish, or Caribbean British |  | |
|  | |  | Black, Black Scottish, Black British |  | |
|  | |  | **Other Caribbean or Black, please specify:** | | |
| **C. Asian, Asian Scottish, or Asian British** | |  |  | | |
| Pakistani, Pakistani Scottish, or Pakistani British |  |  |  | |  |
| Indian, Indian Scottish or Indian British |  |  | **F. Other ethnic group** | | |
| Bangladeshi, Bangladeshi Scottish, or Bangladeshi British |  |  | Arab |  | |
| Chinese, Chinese Scottish, or Chinese British |  |  | **Other, please specify:** | | |
| **Other Asian, please specify:** | |  |  | | |
|  | |  |  |  | |
|  | |  |  |  | |
| If you would prefer not to provide this information, please tick here: | | | |  | |
| If you don't know your ethnicity, please tick here: | | | |  | |

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| **NAME** |  | | | **DOB** | |  | | |
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| What is your main language? | |  | | | | | | |
|  | | | | | | | | |
| Do you need an interpreter or sign language support? | | | **Yes** | |  | | **No** |  |