

NEW PATIENT MEDICAL QUESTIONNAIRE

PERSONAL DETAILS

Surname:

Forename:

Address:

Postcode:

Date of birth:

Tel No: (Home)

(Mobile)

Email:

Would you be happy to be contacted with important/urgent practice news by:

Email: Yes

No

Text Message:

Yes

No

PAST MEDICAL HISTORY

Please list in date order all important illnesses, including any hospital admissions, special investigations and operations.

Year:

Details:

LIFESTYLE

Are or have you been? A current smoker An ex-smoker Never smoked

Do you drink alcohol? YES NO

If you answered YES, please state below roughly how much alcohol you have consumed in the last week:

MEDICATION

Are you at present on any regular medication? If **YES**, please detail below, including the name of the drug(s) and how much you take. Please also include medicines that you take regularly that are not prescribed by an NHS doctor. If you have a list of medication from your previous GP practice, please provide us with a copy of this if possible.

Drug name/strength:

Dosage/Frequency:

Preferred Pharmacy (if known):

CARER STATUS & CARER NEEDS

Are you an unpaid carer for a relative, friend or neighbour?	YES	NO
Do you require the help or assistance of a carer?	YES	NO
Are you housebound?	YES	NO

ALLERGIES & ADVERSE REACTIONS

Please list any substances, including medicines and drugs, to which you are allergic or you are know to suffer an adverse reaction to:

FAMILY HISTORY

Do you have any **family history** of the following health conditions?

Heart disease	YES	NO	Family member(s):
Thyroid disease	YES	NO	Family member(s):
Diabetes	YES	NO	Family member(s):
Asthma/eczema	YES	NO	Family member(s):
Other:			Family member(s):

Please email to: Taymountscrips.Tayside@nhs.scot