BRAIDS MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE

By providing the following information you will help us to understand your medical requirements as well as assisting us with the registration process. The information you give will be treated in the STRICTEST CONFIDENCE. Please complete this form as fully as possible and return it to reception. A P*ractice Brochure* describing the services we offer is available at reception if you do not already have one.

Full name: .....

Maiden name if applicable: .....

Address: .....

Telephone Number: .....

Date of birth: .....

Marital status: .....

Occupation: .....

NHS number (found on medical card): .....

Please list below any major illnesses, operations or accidents that you have had in your lifetime with dates, and name of hospital if relevant. (Use extra space below if necessary!)

Date	Problem	Hospital

In particular, do you have, or have you ever had, any of the following. If so please circle:

Diabetes	Yes/No	Asthma	Yes/No
High blood pressure	Yes/No	Chronic bronchitis	Yes/No
Epilepsy	Yes/No	Arthritis	Yes/No
Heart disease	Yes/No	Depression	Yes/No
Cancer	Yes/No		

If **YES** which type of Cancer?

Have any of your family had any of the above ? If so please provide details:

Relative	Illness/Condition

Prescribed medication: please list any medications that you take regularly (or attach a repeat medication list from your previous GP)

Drug Name	Strength and Dosage Instructions

Allergies: Do you have any allergies? If **YES** please state drug name and type of reaction (e.g. rash, nausea, severe collapse

Next of Kin :

Name:	Address:
Relationship:	Telephone Number:

Carers (A carer is defined as someone who provides regular help with essential daily activities eg washing, dressing, toileting, help with feeding, to another individual without being employed to do so.)

Are **you** a carer ? No ☐ Yes ☐ Who do you care for ?

Are you **cared for** ? No ☐ Yes ☐ By whom ?

Smoking History :-

I have never smoked ☐ I started smoking in (Year) ☐

I stopped smoking in (Year) ☐

I still smoke **or** I used to smoke :- <1 cig/day ☐ 1-9 cigs/day ☐
10-19 cigs/day ☐ 20-39 cigs/day ☐ 40+ cigs/day ☐ I smoke cigars/pipe ☐

Alcohol History:

On an average DAY I drink the following number of units of alcohol:-

A unit is roughly equivalent to a small glass of wine, a half pint of beer or a single measure of spirits.
Zero units ☐ 1 to 2 units ☐ 3 units ☐ 4 units ☐ >4 units ☐

I have had problems in the past drinking excessive amounts of alcohol ☐

Diet

In an average WEEK I eat fruit and vegetables :-

Never ☐ 3 times ☐ Every day ☐

Exercise History

On an average <u>WEEK</u> I exercise to the point of getting out of breath :-

Once per week ☐ 2 times per week ☐ 3 times per week ☐ Every Day ☐

I am not able to take any regular exercise ☐ I am unable to leave my house without help ☐

<u>Bowel Screening</u> - For all patients aged between 50-70 years.

Have you been invited to participate in the Bowel Screening Programme? Y ( ) N ( )
If YES was the result NORMAL ( ) ABNORMAL ( )
If NO and you wish to participate please contact the practice.

<u>For women only</u>

Are You currently pregnant? YES / NO **If yes how many weeks** ☐

Are you immune to Rubella? (German Measles) **YES / NO / DON'T KNOW**

Method of Contraception? (please circle) **PILL COIL CAP SHEATH STERILISATION**

Have you had an hysterectomy? **YES / NO** **DATE :**

Date of last cervical smear? **month / year** **NORMAL / ABNORMAL**

Have you had any tests for cervical cancer? **YES / NO** **DATE:**

<u>Breast Screening</u> – for all women aged between 50-70 years

Have you been invited to participate in the Breast Screening programme? Y ( ) N ( ) DATE:
Do you examine your breasts regularly? Y ( ) N ( )

<u>Ethnic Origin</u> Please indicate your ethnic origin by ticking the box which most closely reflects your background –

White

Scottish ☐ British ☐ Irish ☐ Other White background ☐

Asian, Asian Scottish or Asian British

Indian ☐ Pakistani ☐ Bangladeshi ☐ Other Asian background ☐

Black, Black Scottish or Black British

Caribbean ☐ African ☐ Other Black background ☐

Chinese ☐

Mixed

White & Black Caribbean ☐ White & Black African ☐ White & Asian ☐

Other Mixed background ☐

Any other background ☐

If you do not wish to state your ethnic background please tick this box ☐

Main language spoken …….

Will you require an interpreter when you consult the doctor or nurse ? Yes ☐ No ☐