Today's Date …….

CONFIDENTIAL **(MALE)**

WELCOME TO DANESTONE MEDICAL PRACTICE

Please complete all the questions on this two sided questionnaire. If you are on regular medication please make an introductory appointment with a Doctor.

HAVE YOU EVER BEEN REGISTERED WITH THIS PRACTICE IN THE PAST? YES/NO

SURNAME_____**FORENAMES** _____

MR/TITLE:_____**PREVIOUS SURNAME**_____**DATE OF BIRTH** _____

ADDRESS (inc POSTCODE)_____

HOME TEL _____ **WORK TEL** _____**MOBILE NO** _____

Please tick here if you DO NOT wish to be contacted using your mobile phone number – including by text ☐

EMERGENCY CONTACT NO: _____ **NEXT OF KIN (Name & contact number)**_____

SINGLE/MARRIED/CIVIL PARTNERSHIP/SEPARATED/DIVORCED/WIDOWED/OTHER_____

OCCUPATION _____

ARE YOU A CARER FOR A RELATIVE? _____ **IF YES, PLEASE GIVE DETAILS** _____

DO YOU HAVE A RELATIVE WHO IS YOUR CARER?_____ **IF YES, PLEASE GIVE DETAILS**_____

MAY WE RECORD CARER INFORMATION IN YOUR MEDICAL RECORDS? _____

YOUR PREVIOUS ADDRESS_____

NAME AND ADDRESS OF YOUR PREVIOUS GP _____

Have you had any serious illnesses/operations?

DATE	Hospital (if applicable)	Illness/operation

Do you have any medical problems at the moment? _____

Please list any allergies_____

DOES ANYONE IN YOUR FAMILY SUFFER FROM THE FOLLOWING: (IF 'YES' PLEASE GIVE DETAILS)

• **Diabetes**	**NO / YES (Family Member:**_____**)**
• **Asthma**	**NO / YES (Family Member:**_____**)**
• **High Blood Pressure**	**NO / YES (Family Member:**_____**)**
• **Heart Disease (under 60yrs)**	**NO / YES (Family Member:**_____**)**
• **Heart Disease (over 60 yrs)**	**NO / YES (Family Member:**_____**)**
• **Stroke/Brain Haemorrhage**	**NO / YES (Family Member:**_____**)**
• **Cancer - Breast; Bowel; Cervical; Ovarian; Lung; Prostate; Skin**	**NO / YES (Family Member:**_____**)** **(Type of cancer:**_____**)**

PLEASE TURN QUESTIONNAIRE OVER

Are you taking any tablets, medicines, etc (including those bought from a chemist)? IF YOU HAVE BEEN RECEIVING

REPEAT PRESCRIPTIONS FROM YOUR PREVIOUS GP, PLEASE ATTACH A REPEAT PRESCRIPTION SLIP

Name of Drug	Strength	How often taken

PLEASE NOTE THAT NO REPEAT PRESCRIPTIONS CAN BE ISSUED UNTIL YOU HAVE SEEN ONE OF OUR DOCTORS for your new patient medical

HAVE YOU EVER SMOKED? _____ HOW MUCH PER DAY? _____ CIGARETTES/CIGARS/PIPE
DO YOU SMOKE NOW? _____ HOW MUCH PER DAY? _____ CIGARETTES/CIGARS/PIPE
WHEN DID YOU STOP SMOKING? _____

DO YOU DRINK ALCOHOL? _____ HOW MUCH PER WEEK? _____

WHAT EXERCISE DO YOU TAKE? _____
HOW OFTEN? _____

WHAT IS YOUR HEIGHT? _____WHAT IS YOUR WEIGHT? _____

ETHNIC ORIGIN: We are required by the NHS to record ethnic origin under the following categories. This is to ensure that the NHS provides equality of care for all. You do not have to give these details - please indicate below if you do not wish to.

- ☐ White Scottish
- ☐ Other white British
- ☐ White Irish
- ☐ Other white
- ☐ Other ethnic, mixed
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Other Asian
- ☐ Black Caribbean
- ☐ Black African
- ☐ Other black
- ☐ Other– please state _____

☐ I do not wish to give this information

Do you use an interpreter? YES/NO If "YES" which language? _____

Signed _____Name _____Date _____

Thank you for taking the time to complete this form for us.

DR DAMIAN MCGRORY
DR RHONA McKEOWN
DR KEVIN CORMACK
DR LINZI LUMSDEN

ADMIN USE ONLY ID CHECK
Initials:
Forms of ID verified:
1)
2)