



The Group Practice, Stornoway

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NEW PATIENT HEALTH QUESTIONNAIRE

Thank you for joining our practice. We would be very grateful if you would please complete and return this form to us as soon as possible, and before your New Patient Health Check Appointment.

*** Please bring a sample of urine with you to your appointment.
If you take regular medication please bring your tear off pharmacy medication slip.

Today's date: ____ / ____ / ____

About you Male Female (please tick) Surname:

First names: Date of birth: ____ / ____ / ____

Marital status: Occupation:

How would you like us to contact you? Home phone Mobile

Are you happy for us to leave messages on these numbers? Yes No

Who else lives with you?

Are you a carer for anyone? (If yes please tell us their relationship to you)

Do you have a carer?

Next of Kin

Who is your Next of Kin? What is their relationship to you?

What is their home telephone number? What is their mobile number?

About your health

How would you describe your health?

Do you have a physical or learning disability? Yes No

If yes, please detail.....

Do you smoke? Yes No

If yes, how many a day? Ex-smoker

Do you drink alcohol? Yes No

How many units per week? (1 unit = 1/2 a pint of beer, 1 small glass of wine or 1 standard measure of spirits)

Have you been vaccinated against Tuberculosis (TB) Yes No

(if you are unsure it is likely that you have if you have a scar on your upper arm)

Have you ever been screened for TB (as a contact or a new entrant to the country) Yes No

Have you come from/lived in an area identified as TB high risk Yes No

Do you take any regular medication? Yes No

If you answered yes, please tell us what you take, the dose and how often:

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When was your last medication review? (if more than six months ago we will arrange a review)

Are you allergic to any medicines? Yes No

If yes, please tell us what you are allergic to

Please tick box if either yourself or any of your close family have suffered from the following:

	Yourself	Parent, brother or sister
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
Problems with your Heart	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>

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If you currently have any of the above, when was this last reviewed with a Nurse or GP?

Women only

Last cervical smear	What was the result?	Where was it taken?

For under 16s, please detail immunisation history (please bring your record with you)

Immunisation	Date given

Do you need an interpreter? Yes No If yes, what language is required?

Do you need sign language support? Yes No

Please tick **one** box that best describes your ethnic group or background (not necessarily where you were born) from the list below:

- White Scottish Other White British White Irish Any other white ethnic group Bangladeshi Pakistani
 Indian Chinese Other Asian Black Caribbean Black African Other Black Other Ethnic Group

If there is anything else you think we should know, please provide details below:

The Emergency Care Summary is a summary of basic information about your health which might be important if you require urgent medical care when your GP surgery is closed, or when you go to an accident and emergency department. This means that NHS staff looking after you can access important information about your health, even if they cannot contact your GP surgery.

Do you consent to be included in the Emergency Care Summary?

Yes / No