# The Group Practice, Stornoway

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**Consulting Doctors:**
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## NEW PATIENT HEALTH QUESTIONNAIRE

Thank you for joining our practice. We would be very grateful if you could 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.

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**Today's Date**

**ABOUT YOU:** Male ☐ Female ☐ **Date of Birth:**

**Surname:** **Forename(s):**

**Marital Status:** **Occupation:**

**Please provide us with a mobile number and a home phone number.** It is important that these numbers are up-to-date so we can send you text reminders, and you can access our automated appointment booking system.

**Mobile:** **Home:**

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 phone? 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 provide details:

Do you smoke? Yes ☐ No ☐

If yes, how many a day? Ex-smoker ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐

How many units per week? (1 unit = ½ pint 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

When was your last medication review?

*(if this was more than six months ago we will arrange a review with our Pharmacist)*

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:** | **You** | **Parent or sibling** |
|---|---|---|
| Heart Disease | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| High Blood Pressure1 | ☐ | ☐ |
| Chronic Obstructive Pulmonary Disease (COPD) | ☐ | ☐ |
| Problems with the heart | ☐ | ☐ |
| Other (please specify) | ☐ | ☐ |

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)

Do you need an interpreter? Yes ☐ No ☐ 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 | ☐ | Chinese | ☐ |
| Other White British | ☐ | Other Asian | ☐ |
| White Irish | ☐ | Black Caribbean | ☐ |
| Any other white ethnic group | ☐ | Black African | ☐ |
| Bangladeshi | ☐ | Other Black | ☐ |
| Pakistani | ☐ | Other Ethnic Group | ☐ |
| Indian | ☐ | | |

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 ☐**