GILMORE MEDICAL PRACTICE

New Patient Questionnaire

Welcome to Gilmore Medical Practice. In order for us to provide you with the most appropriate care we would be grateful if you would complete and return the attached questionnaire.

Have you been a patient with us before?	YES / NO
Title (e.g. Mr/Mrs/Miss/Ms/Other)	
Forename/s	
Surname	
Date of Birth (DD/MM/YYYY)	
Address including postcode	
Mobile number	
Landline number	
Email address	
Do you consent to receiving text messages from the surgery e.g. appointment reminders?	YES / NO
Gender at birth	
Current gender	
Preferred pronouns	
Ethnicity	
Do you require an interpreter / translator?	YES / NO
If yes, please specify the language required	
Marital status	
Are you a student?	YES / NO
Date leaving the UK (if applicable)	
Preferred pharmacy	
Name of Emergency Contact / Next of Kin	
Emergency Contact / NOK relationship to you (e.g. wife, brother, friend)	
Emergency Contact / NOK telephone number	
Do you care for someone? (e.g. a relative or friend outwith normal childcare)	YES / NO

Name and DOB of all patients at same address (continue on back page if required)	
Name:	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB:

<u>Medical Problems</u> - Please list any medical problems you may have, have had or any operations (continue on back page if required):

Date diagnosed / Date of Operation	Medical Problem / Operation

<u>Personal / Family History</u> - Please circle if you, or a member of your family have had any of the following:

Personal		Family (mother, father, sister or brother)	
Heart Attack	YES / NO	Heart Attack (before the age of 60)	YES / NO
Angina	YES / NO	Angina	YES / NO
Stroke	YES / NO	Stroke	YES / NO
High Blood Pressure	YES / NO	High Blood Pressure	YES / NO
Asthma	YES / NO	Asthma	YES / NO
Diabetes	YES / NO	Diabetes	YES / NO

<u>Immunisations</u> - Please give details of any immunisations you have received and the country you received them in (continue on back page if required):

Vaccination	Date	Country

<u>Allergies</u> - Do you have any allergies? If yes, please list below (continue on back page if required):

Allergy	Severity (Please circle)
	Mild / Moderate / Severe
	Mild / Moderate / Severe
	Mild / Moderate / Severe

<u>Cervical Screening (Smear Test / Pap Smear)</u> - Please give details including the country you had this in:

Date of last cervical smear	Country	Result
		Normal / Abnormal

<u>Smoking / Electronic Cigarette (e.g. Vapes)</u>

Do you smoke?	YES / NO
Have you ever smoked?	YES / NO
If you are a smoker, how many a day?	
Do you use electronic cigarettes?	YES / NO
If yes, how often?	

<u>Alcohol</u> - Please advise your usual average alcohol intake. 1 unit = 1 small glass of wine, half a pint of beer or a single measurement of spirits.

How many units of alcohol do you drink per week?	units

<u>Medication</u> - Are you taking any regular medication including contraception? If yes, please list below. If possible, please attach you repeat prescription list from your previous practice:

Drug Name e.g. Loratidine	Strength e.g. 10mgs	Dose Instructions e.g. 1 tab in the morning	Illness Prescribed for e.g. Hayfever
Drug Allergies (please state drug name and type of reaction e.g. rash, nausea, severe collapse):			

Please indicate if you need any of the below services:

Contraception appointment with the Nurse (for patients already taking contraception)	YES / NO
Wellbeing / Mental Health appointment with the Nurse	YES / NO
Telephone appointment with our practice Pharmacist to discuss repeat medication	YES / NO
Chronic Disease appointment with the Nurse (Diabetes, Hypertension, Heart Disease, Asthma or COPD)	YES / NO
Hepatitis C blood Test (18+ year old) Are you from North Africa, Asia, the Middle East or Pacific Islands? If you have never been tested for Hepatitis C we can arrange for this to be done by the Nurse	YES / NO
Key Information Summary I consent for the practice to allow the hospital and emergency services access to a summary of my medical conditions/next of kin/or special information about my health needs	YES / NO
Do you have a Social Worker? If yes, please provide their name and their contact details:	YES / NO

Blood Pressure: Guidelines for good practice advise that patients over the age of 40 have their blood pressure checked once every 5 years. If you have not had this done, please make an appointment with the practice nurse to have this checked.