BALLATER CLINIC

NEW PATIENT QUESTIONNAIRE

Please complete this **confidentia**l form Date:

Name	Date of Birth
Address	
Post Code	
Home No.	Mob No.
Email address.	

Relative or friend to contact in an emergency

Name	Tel No.
Address	
Relationship of Relative/Friend	
Are you a Carer - Do you look after a relative or friend	Yes☐ No☐
If Yes – Name	

MEDICAL HISTORY

Do you suffer from any of the following:	
Diabetes☐ Epilepsy☐ Asthma☐ Stroke☐ Angina☐ High Blood Pressure☐	
Heart Attack☐ COPD☐ Atrial Fibrillation☐ Peripheral Vascular Disease☐	
Have you ever had any major operations/serious illness☐ If yes please detail below	
Operation/Illness	Date

MEDICATION

Please list any regular medication, including the dosage and how often taken

Name of Drug	Strength	How often taken

Are you allergic to any medication Yes☐ No☐

Name of Drug	Reaction experienced

Do you suffer from any other allergy ie peanuts, eggs etc ☐

Allergy……

Ladies Only

Have you had a cervical smear Yes☐ No ☐

Do you have a Coil, Implanon or Nexplanon fitted? Yes☐ No☐

Date fitted/last check up:…....

Health Promotion
Smoking Habits:

Current Smoker		How many cigars/cigarettes do you smoke per day		Date Started
Ex Smoker		How many cigars/cigarettes did you smoke per day		Date Stopped
Never smoked				

Alcohol consumption

Please estimate your alcohol intake per week (1 unit = half pint of beer or 1 glass of wine (125ml or small glass) or 1 pub measure of spirit)

Number of units per week	

FAMILY HISTORY

	Age and state of health	Age at death and cause
Mother		
Father		
Brothers		
Sisters		

Any **hereditary disease** in your family? Eg Glaucoma, Cystic Fibrosis

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Date of last **Tetanus** immunisation:……..

Please bring a sample of urine to your patient registration with the Practice Nurse