BALLATER CLINIC

NEW PATIENT QUESTIONNAIRE

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

Name:	Date of Birth:
Address:	
Post Code:	
Home Tel No.	Mob No.
Email address:	
Tick box if you **DO NOT** wish to be contacted by SMS or E-mail ☐	
Occupation:	

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, please give details	
Do you have a Carer? Yes☐ No☐ If yes, please give details	

MEDICAL HISTORY

Do you suffer from any of the following?:

Diabetes ☐ Epilepsy ☐ Asthma ☐ Stroke ☐ Angina ☐ High Blood Pressure ☐

Heart Disease ☐ COPD ☐ Atrial Fibrillation ☐ Cancer ☐

Peripheral Vascular Disease ☐ Mental Health Problems/Depression ☐

Have you ever had any major operations/serious illness? Yes ☐ No ☐

If yes please detail below:

Operation/Illness	Date
Immunisations:	
Date of last Tetanus Immunisation:	

MEDICATION

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

Name of Drug	Strength	How often taken

If you are on repeat medication you can ask to register for our online service.

Are you allergic to any medication Yes ☐ No ☐

Name of Drug	Reaction experienced

Do you suffer from any other allergy i.e. peanuts, eggs, etc? Yes ☐ No ☐

Allergy	Reaction experienced

LIFESTYLE

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 Please provide details		

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:…....

All New Patients - Please bring a sample of urine to your patient registration appointment with the Practice Nurse