DINGWALL MEDICAL GROUP
New Patient Questionnaire

Please return this questionnaire along with your registration form. The registration process can take some time, completing this questionnaire will help us while we await your record from your previous practice. This form should be completed for all patients aged 5 and over and under 5s with significant medical history.

If you have any problems completing the form, please ask for assistance at reception. A large print version of this form is available.

You should also make an appointment for a New Patient Check with the Health Care Assistant who will check your height, weight, blood pressure, arrange any blood tests, assist with medications and advise on any further appointments you may need with the Doctor or the Nurse.

First Names: _____ **Surname:** _____

Date of Birth: _____ Former Name: _____

Home Tel No: _____ Mother's Maiden Name: _____

Work Tel No: _____ Town of Birth: _____

Occupation: _____ Male or Female: _____

Mobile No: _____

Do you consent to communication by text message (SMS) from us? Yes/No (Over 16's only)
This may include appointment reminders, annual review/flu vaccine reminders and requests to contact the practice.

Please delete as appropriate: Married / Widowed / Divorced / Separated / Single / Partner

Ethnicity: _____

Can you communicate easily in English? Yes / No

Interpreter needed (state language): _____

Carers

Are you the **main carer** for somebody, on a voluntary basis? **Yes / No**
If yes, with permission, please state who: _____
Are they registered with Dingwall Medical Group? **Yes / No**

Do you have somebody who is **your carer**? **Yes / No**
Please add the name of your voluntary carer: _____
Are they registered with Dingwall Medical Group? **Yes / No**
Do you consent to them being contacted on your behalf? **Yes / No**

Smoking Status Do you smoke? **Yes/No/Never** Do you need advice **Yes / No**

Alcohol Intake Do you drink alcohol? **Yes / No** Do you need advice **Yes / No**

PAST MEDICAL HISTORY

Do you or have you ever suffered from any of the conditions below, please circle.

Heart

- Heart Attack **Yes / No** Approximate dates _____
- Angina **Yes / No** Approximate date it started _____

If you have had heart problems:
Have you ever had an EXERCISE ECG (Treadmill) **Yes / No**
Have you ever had an ULTRASOUND SCAN OF YOUR HEART **Yes / No**
Have you ever seen A DOCTOR AT THE HOSPITAL FOR YOUR HEART **Yes / No**

- Do you have any other heart problems? _____

High Blood Pressure **Yes / No** When was it first diagnosed _____

Stroke **Yes / No** Approximate date/s _____

Diabetes **Yes / No** When was it first diagnosed _____

Epilepsy **Yes / No** When was it first diagnosed _____
When was your last fit _____
How often do you have a fit _____

Thyroid
Overactive Thyroid **Yes / No** When was it first diagnosed _____
Underactive Thyroid **Yes / No** When was it first diagnosed _____
Do you receive treatment for it, if so, what: _____

Asthma **Yes / No** When was it first diagnosed _____
Is it still a problem **Yes / No**

Chronic Bronchitis or Other Chest Complaints **Yes / No**
Please Specify: _____

Cancer **Yes / No**
What type of cancer _____
When _____
What treatment did you receive _____

Have you been attending any Hospital clinics immediately prior to joining this practice? Yes / No

If yes, please give some brief details: _____

Have you had any operations? Yes / No
If yes, please list:

Blood Transfusions Did you have a blood transfusion before 1991? Yes/No
If yes, do you wish advice? Yes/No

Are there any other conditions or information about your health that we should know about?

_____

_____

Family History Please include significant health problems of immediate family members (immediate means grandparents, parents, brothers, sisters and your children)

_____

_____

Immunisations Are your immunisations up to date? **Yes / No**

8 weeks	DTaP/IPV/HIB/PCV/MenB/Rotavirus	Date _____
12 weeks	DTaP/IPV/HIB/MENC/Rotavirus	Date _____
16 weeks	DTaP/IPV/HIB/PCV/MENB	Date _____
12 months	HIB/MENC/MMR/PCV	Date _____
Pre-school	DTaP/IPV/MMR Booster	Date _____
Secondary School:		
	BCG (if required after heaf test)	Date _____
	Diptheria/Tetanus/Polio Boosters	Date _____

Others (type & date) _____

Current Medications
Please include all current medications below, if you have a repeat prescription from your previous Doctor it would be helpful to hand that in also. If you are due to run out of your medication shortly please arrange a prescription through your existing practice while we process your registration.

Name_____ Strength_____ How often you take it _____
Name_____ Strength_____ How often you take it _____
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Repeat medications can be ordered using the online form on our website (www.dingwallmedicalgroup.co.uk) or at reception. Please allow us 48hours for requests to be processed and remember the chemist may also require further processing time.

Please state any known reaction to medicines or drugs below, include drug name and reaction type:

_____

_____

Do you have any other allergies?

_____

_____

WOMEN ONLY

Pregnancies

Please specify the dates of birth and type of delivery (normal/forceps/suction/section) of any children you have had.

Date of Birth	Type of Delivery	Sex	Any problems?

Have you had any miscarriages? **Yes / No** If yes, at how many weeks? _____

Contraception

Have you a coil fitted **Yes / No**
Have you an implant fitted **Yes / No**
Are you taking the pill **Yes / No**

Cervical Smear

Have you ever had a cervical smear? **Yes / No**
Date of the last smear, if applicable _____

Thank you for completing the New Patient Questionnaire.

Further information about the Dingwall Medical Group can be found in the Practice Booklet you should have received when registering, or on our website: www.dingwallmedicalgroup.co.uk

We also post updates on our practice Facebook page at: www.facebook.com/dingwallmedicalgroup