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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tick this box if you DO NOT give consent to communication by text message (SMS) from us.**

**(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?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 Secondary School:  |   | Date \_\_\_\_\_\_\_\_\_\_  |
|  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 \_\_\_\_\_\_\_\_\_  |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_  | How often you take it \_\_\_\_\_\_\_\_\_  |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_  | How often you take it \_\_\_\_\_\_\_\_\_  |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_  | How often you take it \_\_\_\_\_\_\_\_\_  |
| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strength\_\_\_\_\_\_\_   | How often you take it \_\_\_\_\_\_\_\_\_  |
| **Repeat medications can be ordered using the**  | **online form on our website**  |

[**(**www.dingwallmedicalgroup.co.uk**)**](http://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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any other allergies?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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](http://www.dingwallmedicalgroup.co.uk/)

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