Crosshouse Medical Practice

New Patient Questionnaire

Your Details

Name			
Address			
Landline Telephone		Mobile	
Height		Weight	
Date of Birth			
Marital Status			
Occupation			
Next of Kin & contact details			
Are you a carer for someone? Please give details.			

Have you been registered with this practice before? Yes ☐ No ☐

Please note if you have previously been removed from the practice list due to aggressive behaviour or failing to attend appointments you will not be re-registered.

Main Language Spoken: English ☐ Other ☐ British Sign Language ☐

If other, please specify: _____

Do you require an interpreter? Yes ☐ No ☐

Ethnicity

White Scottish	☐	Other white British group	☐
White Irish	☐	Other white ethnic group	☐
Indian	☐	Bangladeshi	☐
Chinese	☐	Other Asian ethnic group	☐
Black African	☐	Other black ethnicity	☐
Other ethnic, mixed origin	☐		

Crosshouse Medical Practice

Medical Problems

Do you have any current medical problems? Yes ☐ No ☐

Please indicate which medical problems you have:

Asthma	☐	Depression	☐	Learning Disabilities	☐
Atrial Fibrillation	☐	Diabetes	☐	Mental Health Problems	☐
Cancer	☐	Epilepsy	☐	Osteoporosis	☐
Heart Disease	☐	Heart Failure	☐	Peripheral Arterial Disease	☐
COPD	☐	Hypertension	☐	Rheumatoid Arthritis	☐
Dementia	☐	Hypothyroidism	☐	Stroke / TIA	☐

If you have any other conditions not indicated above, please give details in the space below:

Serious Illness and Surgical Procedures

Have you ever had any serious or significant illnesses or surgical procedures?

If yes, please give details in the space below:

Date	Description of Illness or Surgical Procedure

Crosshouse Medical Practice

Medication

Are you allergic to any medications? YES ☐ NO ☐

Are you allergic to any other substances? YES ☐ NO ☐

If you have any allergies, please provide details in the space below:

Please provide details of any medication you are currently taking:

Vaccinations

Your medical records may take some time to arrive in the practice. If you are currently due any vaccinations please provide details in the space below:

Crosshouse Medical Practice

Family History

Please list any particular illnesses or diseases that run in your family in the box below. Please include details of heart disease in parents, brothers, and sisters and the approximate age at which it occurred.

Lifestyle Information

Smoking

Please complete the following boxes:

Never Smoked Tobacco ☐	Ex-Smoker ☐ Amount per day? When did you stop?	Current Smoker ☐ Amount per day? ***We advise all smokers to stop smoking. For advice see your GP or contact Fresh Airshire on 01292885827.***

Do you use electronic cigarettes? Yes ☐ No ☐

Alcohol

How many units of alcohol do you consume in a typical week? _____

1 unit of alcohol is the equivalent of:

- ½ pint of regular strength beer
- 1 alcopop
- 1 small glass of white wine
- 1 measure of whisky

Physical Activity

How often do you exercise?

- Three or more times a week ☐
- Twice a week ☐
- Once a week ☐
- Less than once a week ☐

Crosshouse Medical Practice

Drug Misuse

Do you currently use illicit drugs? Yes ☐ No ☐

Have you used illicit drugs in the past? Yes ☐ No ☐

Female Health Issues

Have you had a cervical smear test? Yes ☐ No ☐
If yes, when was this last done? _____

Have you had a breast screening test? Yes ☐ No ☐
If yes, when was this last done? _____

Do you currently use contraception? Yes ☐ No ☐
If yes, what contraception do you use? _____

Are you currently pregnant? Yes ☐ No ☐

How many pregnancies have you had? _____

How many children do you have? _____

Patient Signature: _____

Date: _____

For surgery use only

No appointment required ☐
GP appointment ☐ Details: _____
Nurse appointment ☐ Details: _____
HCA appointment ☐ Details: _____
Phlebotomy appointment ☐ Details: _____
Admin ☐ Details: _____

Reviewed by: _____

Date: _____