

BRUNTSFIELD MEDICAL PRACTICE

11 Forbes Road, Edinburgh, EH10 4EY

Date Form Completed:	
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In order to be fully registered with this practice, this form **MUST** be completed

NEW PATIENT HEALTH QUESTIONNAIRE (FOR ADULTS 16 YEARS +)

TITLE:		FIRST NAME:			
SURNAME:					
DATE OF BIRTH:		GENDER:	M <input type="checkbox"/>	F <input type="checkbox"/>	(please tick)
MARITAL STATUS:					
ADDRESS (incl flat no):			WHO ELSE LIVES IN THIS HOUSEHOLD?		
			ARE YOU A CARER FOR SOMEONE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
			If yes, please specify:		
HOME TEL:		WORK TEL:		MOBILE TEL:	
EMAIL ADDRESS:					
NEXT OF KIN: (Name, Address, Tel No.)					
ARE YOU HAPPY TO HAVE MESSAGES LEFT ON THE FOLLOWING NUMBERS?	HOME TEL:	YES <input type="checkbox"/>			
	MOBILE TEL	YES <input type="checkbox"/>			
OCCUPATION:					
ARE YOU CURRENTLY A STUDENT?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	IF YES, WHERE?		
HAVE YOU BEEN A MEMBER OF THE UK ARMED FORCES FOR AT LEAST ONE DAY?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	IF YES, SERVICE NO:		
				DATE STARTED:	

HOW DID YOU FIND OUT ABOUT THE PRACTICE / DECIDE TO REGISTER WITH US?					
I've been registered here before	<input type="checkbox"/>	I have family registered here	<input type="checkbox"/>	General word of mouth	<input type="checkbox"/>
NHS helpline or website	<input type="checkbox"/>	Non-NHS ad or weblink	<input type="checkbox"/>	Search engine (e.g. Google)	<input type="checkbox"/>
Other (please specify):					

SMOKING HABIT				
Are you a current smoker? YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)	If Yes		If No	
		No. Cigarettes per day?		Have you ever smoked?
	No. Cigars per day?		If yes, what year did you stop?	
	Pipe tobacco per week? (oz / grams)		How many <i>did</i> you smoke per day?	
	Would you like help to stop?	YES <input type="checkbox"/> NO <input type="checkbox"/>		

ALCOHOL INTAKE	
Do you drink alcohol?	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
If Yes: Wines / Spirits: units per week	
Beer: units per week	
1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer	

EXERCISE HABIT	
Do you take regular exercise?	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
If Yes: What sort : (eg. Tennis, walking)?	
For how long at any one time?	
How many times weekly?	

MEDICATION	
ARE YOU ON ANY REGULAR MEDICATION? (including the contraceptive pill)	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
If Yes, please state name and dose:	
(Please note you will be required to see the doctor for a first repeat prescription to be issued)	
ARE YOU ALLERGIC TO ANY MEDICINES?	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
If Yes, please state type and name:	

WOMEN ONLY					
Date of Last Smear?		What was the Result?		Where was it taken?	
No. of Pregnancies ?		No. of Children?		Are you pregnant now?	

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) :

High Blood Pressure <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Diabetes <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Heart Disease <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Angina <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Epilepsy <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Stroke <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Asthma <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Cancer <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If Asthmatic , have you used your inhaler in past 12 months?	YES <input type="checkbox"/> NO <input type="checkbox"/>		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had :

	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY

Has a first degree relative (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Stroke	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Heart Disease	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	

Do any other illnesses run in your family? YES NO

If Yes, Please give details:

Please give details of the current state of your family's health:

	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Sibling(s)				

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the practice

NAME _____ **DOB** _____

What is your main language?

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Do you need an interpreter or sign language support? **Yes** **No**

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
Scottish	
English	
Welsh	
Northern Irish	
British	
Irish	
Gypsy/Traveller	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

D. African	
African, African Scottish, or African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean Scottish, or Caribbean British	
Black, Black Scottish, Black British	
Other Caribbean or Black, please specify:	

C. Asian, Asian Scottish, or Asian British	
Pakistani, Pakistani Scottish, or Pakistani British	
Indian, Indian Scottish or Indian British	
Bangladeshi, Bangladeshi Scottish, or Bangladeshi British	
Chinese, Chinese Scottish, or Chinese British	
Other Asian, please specify:	

F. Other ethnic group	
Arab	
Other, please specify:	

If you would prefer not to provide this information, please tick here:	
If you don't know your ethnicity, please tick here:	