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| **New Patient Questionnaire** |
| **PERSONAL INFORMATION** |  |
| SURNAME: |  | FORENAME: |  | DATE OF BIRTH: |  |
| MARITAL STATUS: |  | SEX: |  |
| ADDRESS: |  |  |  |
| TELEPHONE NUMBER:MOBILE NUMBER: |  | EMAIL ADDRESS: |  |
| SURNAME AT BIRTH: |  |  | TOWN OF BIRTH: |  |  |
| NEXT OF KIN (*with contact details*) |  |
| Named Carer for Patient (*if applicable*) |  |
| Do you or have you ever served in the UK armed forces? | YES NO  |
| **HEALTH INFORMATION** |  |
| DO YOU SMOKE? | YES NO  | HAVE YOU EVER SMOKED? | YES NO  |
|  | IF YES HOW MANY PER DAY? |  |
|  | IF YES DATE STOPPED |  |
| HEIGHT |  | WEIGHT |  |
| DO YOU DRINK ALCOHOL? | YES NO | IF YES HOW MANY UNITS PER WEEK? |  |
| DIET (*mixed/vegetarian/other*) |  |
| **MEDICAL HISTORY** |  |
| ILLNESSES *(e.g. DIABETES/ASTHMA/HEART ATTACK/CANCER/TB/HIGH BLOOD PRESSURE etc.)* | OPERATIONS *(e.g. TONSILECTOMY/ HYSTERECTOMY/VASECTOMY etc.)* |
| YEAR DIAGNOSED | DETAILS | YEAR  | DETAILS |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **ANSWER IF BORN BEFORE 1996** |  |
| DID YOU/ IS IT POSSIBLE THAT YOU HAD A BLOOD TRANSFUSION BEFORE 1996?  | YES NO  |
| HAVE YOU BEEN CONTACTED ABOUT THE SCOTTISH INFECTED BLOOD INQUIRY? | YES NO  |
| **FAMILY MEDICAL HISTORY** |  |
| ILLNESSES *(e.g. DIABETES/ASTHMA/HEART ATTACK/CANCER/TB/HIGH BLOOD PRESSURE etc.)* |
| YEAR DIAGNOSED | DETAILS | YEAR DIAGNOSED | DETAILS |
|  |  |  |  |
|  |  |  |  |
| **MEDICATION** | *PLEASE GIVE DETAILS OF ANY MEDICATION AND DOSAGE*  |
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|  |
| **FEMALE HISTORY** |  |
| HOW MANY PREGNANCIES HAVE YOU HAD? |  | DATES |  |
| HAVE ANY OF THEM ENDED IN: | IF YES WHICH ONE? |  |
| MISCARRAIGE | YES NO |  |  |
| STILLBIRTH | YES NO |  |  |
| DIFFICULT DELIVERY | YES NO |  |  |
| ARE YOU USING ANY FORM OF ORAL CONTRACEPTION? | YES NO | IF YES, FOR HOW LONG? |  |
| HAVE YOU HAD A CERVICAL SMEAR TEST? | YES NO | IF YES, WHEN AND WHERE? |  |
|  | IF NO, WOULD YOU LIKE ONE? | YES NO |
| HAVE YOU EVER HAD BREAST SCREENING? | YES NO | IF YES WHEN AND WHERE? |  |
| **FURTHER DETAILS** | PLEASE GIVE DETAILS |
| ANY DISABILITIES(*e.g. blind/deaf/amputations etc*) |  |
|  |
| ANY ALLERGIES/SENSITIVITIES*(e.g. Penicillin/Aspirin/Skin reaction etc.)* |  |
|  |
| **IMMUNISATION/VACCINATION RECORD** | PLEASE GIVE DETAILS |
| **DETAILS** | **YEAR** |
| POLIO TRIPLE |  |
| TETANUS |  |
| MMR |  |
| BCG |  |
| OTHER *(please state)* |  |