**AIRD MEDICAL PRACTICE**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to the practice. It will help us to provide you with medical care if we know something about you. Please print answers to as many questions as you feel able to.

**HAVE YOU BEEN REGISTERED AT THIS PRACTICE PREVIOUSLY? Yes or No**

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

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

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

Have you any condition for which you regularly visit the doctor? If so:-

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illnesses or operations in the past? If so:-

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following?

Angina or heart attack Yes / No

Diabetes Yes / No

High blood pressure Yes / No

Stroke or TIA (mini stroke) Yes / No

Has a first degree relative (parent or sibling) had any of the following?

Angina or heart attack Yes / No (WHO & AT WHAT AGE?)

Diabetes Yes / No (WHO & AT WHAT AGE?)

Please give details of any other serious illnesses that run in your family.

sue/newpatientpaperwork/practicequestionnaire **PTO →**

Are you taking tablets or medicines, or having injections?

If so, please state:-

NAME DOSE No OF TIMES PER DAY

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

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

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

Are you allergic to any medicine, tablets or injections?

If so, please state:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: Single / Married / Divorced / Separated / Re-married / Widowed

Do you have any children? If so, please state ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you care for someone who would have difficulty managing if you were unwell? If so, can you tell us who they are and a little about them?

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

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

Do you have a job? Yes / No. If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING:** Never smoked

*(Please tick which* Given up smoking

***one*** *applies)* Smoke \_\_\_ per day

**WOULD YOU LIKE US TO CONTACT YOU**

**WITH SUPPORT TO STOP SMOKING? YES / NO**

**ALCOHOL:** Your intake is within recommended limit

(\*\*See bottom of page) Your intake is above recommended limit

You have stopped drinking alcohol

*(Please tick which* You are a current non–drinker

***one*** *applies)* You are teetotal

**EXERCISE:** Exercise is:

physically impossible

*(Please tick which* OR you avoid even trivial exercise

***ONE*** *applies)* OR you enjoy light

**OR** you enjoy moderate

**OR** you enjoy heavy exercise

OR you are a competitive athlete

**FOR WOMEN ONLY**

Have you ever had a cervical smear? Yes / No

If yes, which year? \_\_\_\_\_\_\_\_\_\_

Have you ever had a breast examination or mammogram? Yes / No

If yes, which year? \_\_\_\_\_\_\_\_\_\_

\*\* 1 unit of alcohol is 1 glass of wine or half a pint of beer or 1 measure of spirits. Recommended weekly intake is 14 for men and women.

|  |  |
| --- | --- |
| **ETHNIC GROUP QUESTIONNAIRE** | |
|  | PLEASE TICK BOX |
| **A. WHITE** | |
| SCOTTISH |  |
| OTHER BRITISH |  |
| IRISH |  |
| ANY OTHER WHITE BACKGROUND (please specify) |  |
|  | |
| **B. MIXED** | |
| ANY MIXED BACKGROUND (please specify) |  |
|  | |
| **C. ASIAN, ASIAN SCOTTISH, ASIAN BRITISH** | |
| INDIAN |  |
| PAKISTANI |  |
| BANGLADESHI |  |
| CHINESE |  |
| ANY OTHER ASIAN BACKGROUND (please specify) |  |
|  | |
| **D. BLACK, BLACK SCOTTISH, BLACK BRITISH** | |
| CARIBBEAN |  |
| AFRICAN |  |
| ANY OTHER BLACK BACKGROUND (please specify) |  |
|  | |
| **E. OTHER ETHNIC BACKGROUND** | |
| ANY OTHER BACKGROUND (please specify) |  |
|  | |
| **F. OTHER** | |
| PREFER NOT TO SAY |  |