# EAST LINTON SURGERY

## NEW PATIENT QUESTIONNAIRE

As a new patient to our practice we ask that you complete this questionnaire with your current and up to date details. Following completion of the form you may be asked to make an appointment with either the GP, or Nurse.

| **Name:** | **Title:** | **Date of birth** | |
|---|---|---|---|
| **Address:** <br><br> **Postcode:** | | | |
| **Telephone no's** | **Landline** _____ | **Mobile** _____ | |

| *Medical History* <br> Do you currently, or have you ever suffered from any of the conditions listed below? | | |
|---|---|---|
| **Condition** | **Circle Yes or No** | **Further information (last review etc)** |
| Asthma | **Yes or No** | |
| Other respiratory diseases | **Yes or No** | |
| Heart condition | **Yes or No** | |
| Diabetes | **Yes or No** | |
| Stroke | **Yes or No** | |
| High blood pressure | **Yes or No** | |
| Skin conditions | **Yes or No** | |
| Operations | **Yes or No** | |
| Mental illness | **Yes or No** | |
| Stress related illness | **Yes or No** | |
| Known Allergies | **Yes or No** | |
| Are you a Carer? | **Yes or No** | |

| | | |
|---|---|---|
| ***Female patients only*** | **Are your cervical smears up to date?** | **Yes or No** |
| | **If over 50, date of last mammogram?** | |

*Medication*

Please list medication you take regularly at the moment, include those you buy from a pharmacy or supermarket

| | | |
|---|---|---|
| **Medication name along with dose and frequency:** | 1. | 5. |
| | 2. | 6. |
| | 3. | 7. |
| | 4. | 8. |

| *Lifestyle* (*Only for completion by those ≥ 15 years of age*) | | | | |
|---|---|---|---|---|
| **Smoking status** (Tick one) | **Current** | ☐ | How many/day | ☐☐ |
| | Would you like to stop smoking at some point? | | | **Yes** or **No** |
| | **Past** | ☐ | Stop date | __/__/____ |
| | **Never smoked** | ☐ | | |
| **Alcohol intake** | Do you drink alcohol? (Tick Yes or No) | Yes ☐ → | Units per wk? → | ☐☐* |
| | | No ☐ | *1 unit = 1 measure of spirits, 1 small glass of wine or half a pint of beer | |
| **Exercise** | Do you currently do any exercise? (Tick Yes or No) | Yes ☐ → | More info: | |
| | | No ☐ | Is this something you would like to consider in the future? **Yes** or **No** | |

**<u>Please provide us with a next of Kin who we can contact in the event of an emergency. This information will be recorded in your medical record and only used in the event of an emergency.</u>**

**Next of Kin Name:**

**Relationship to you:**

**Their Contact telephone number:**