SCOTSTOWN MEDICAL GROUP

New Patient Questionnaire

Surname _____ Forename/s _____

Date of Birth _____ Maiden Name _____

Work Tel No _____ Mobile _____ Home Tel No _____

Marital status _____ Occupation _____

Name of Emergency Contact _____ Relationship _____

Their Daytime Tel No _____ Evening/Mobile No _____

E-Mail address _____

OTHER PEOPLE WHO LIVE AT THE SAME ADDRESS

Name	Date of Birth	Relationship to you

ETHNIC ORIGIN

Please tick the appropriate box – or the last box if you do not wish to give this information

9S13 White Scottish		9S6 Indian	
9S14 Other White British		9S7 Pakistani	
9S11 White Irish		9S8 Bangladeshi	
9S12 Other White Ethnic		9S9 Chinese	
9SB Other Ethnic Mixed Origin		9SH Other Asian Ethnic Group	
9S2 Black Caribbean		9SJ Other Ethnic Group	
9S3 Black African			
9SG Other Black Ethnic Group		9SD Ethnic Group - refused	

Please tell us about serious illnesses in your family especially heart disease, strokes, cancer, asthma, diabetes and glaucoma

	Age	Illness	Age of onset	Age of death	Cause of death
Father					
Mother					

If you need to see a GP or nurse please bring any medication you are taking to your first appointment.

Height _____ Weight _____

Usual type of alcohol taken is _____ Alcohol: _____ units per day
(One unit is about ½ pint of beer, one pub measure spirits or one glass of wine)

SMOKING STATUS – ARE YOU? – PLEASE CIRCLE ONE

A smoker Yes/No How Many Per Day? _____
An Ex-smoker Yes/No If so when did you stop? _____
Never smoked Yes/No

SERIOUS ILLNESS, NOW OR IN THE PAST

Type of Illness (e.g. diabetes)	Approximate date of Onset

YOUR MEDICATION, INLCUDING CONTRACEPTIVE PILL

Name	Strength (e.g. 50mg)	Frequency (e.g. one a day)

Any adverse reactions to medicine?

Name of Medicine	Type of Reaction

DO YOU HAVE PRIVATE HEALTH CARE INSURANCE? YES/NO

CARER STATUS

Do you care for someone at home but you do not get paid? YES/NO
Does someone care for you at home (unpaid)? YES/NO

FOR OFFICE USE ONLY - IS A CARER CODE 918G
HAS A CARER CODE 918F