KERSLAND HOUSE SURGERY, 37 Station Rd, Milngavie – 956 1005

New Patient Questionnaire

Today's Date _____

Surname _____ **Previous Surname(s)** _____

Forenames _____ **Marital Status** _____

Date of Birth _____ **Occupation**_____ **Work tel no.** _____

Home tel no. _____ **Mobile no** _____

Next of kin(name & contact no.) _____

Email address _____

Have you ever served in the Army/Navy/ RAF?(if so which service and date please) .....

I agree that by supplying the above e-mail/telephone number that the surgery can contact me using these methods –

Signature ..... **Date**.....

What is your ethnic group? Choose **ONE** section from A to E, then tick the appropriate box to indicate ethnic group

A White group

- ☐ British
- ☐ Irish
- ☐ Other

B Mixed

- ☐ White/Black African
- ☐ White/Black Caribbean
- ☐ White and Asian
- ☐ Any other mixed

C Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian

D Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Other

E Chinese or other ethnic

- ☐ Chinese
- ☐ Other

Do you require an interpreter..... YES/NO

Carers: Do you look after someone or does someone regularly help you? (name & contact no)

_____

Height: _____ **Weight:** _____

Do you smoke? ☐ Yes ..... Daily

☐ No – given up When?_____ How many did you used to smoke a day?_____

☐ No – never smoked

How much alcohol do you drink per week? _____ units

(1 unit = 1 small glass of wine/1 single spirit/half pint beer)

(FOR WOMEN ONLY – Number of pregnancies ..... Number of children.....

Date of last smear (month & year if possible) .....)

Please list any allergies or any record of bad side effects from any medication _____

_____

Hospital Admissions – please list any operations, major illnesses and medical conditions for which you take regular medications. (including broken bones or bad sprains) Date & year _____

_____

Current Medication Please list name, dose/strength and number of times taken daily

_____ _____

_____ _____

_____ _____

Do you currently attend any hospital as an outpatient? If so please list

_____

Family History Did anyone in your family suffer from....

	Age (At onset)	**Who?** (which family member/s)	
Diabetes	.....	.....	
Heart Attack	.....	.....	
Stroke	.....	.....	
Cancer	.....	.....	**Which type?**.....
Any other	.....	.....	

Thank you for completing this form

☐ **Meds OK, update computer**

☐ **Appointment with nurse/doctor**

☐ **File**