Kippen Surgery New Patient Questionnaire

Welcome to Kippen Surgery. Please help us by providing some information about yourself. The information provided is confidential and will be held as part of your Medical Records.

Date:	Mr / Mrs / Miss / Ms / Other	(please circle)		
Name:	Date of Birth:	Date of Birth:		
Address:				
Post Code:	Occupation:			
Phone No:	Mobile No:			
Medical History –				
•				
1. Do you or have you had any of	the following? –			
Asthma	Thyroid Disease	7		
Diabetes	Arthritis			
High Blood Pressure	Eczema			
Stroke	Hay Fever			
Heart Attack	Peptic Ulcer Disease			
Epilepsy	Any bowel Disorder			
Chronic Bronchitis	Anxiety / Depression			
Cancer	Other			
2. Please list any operations or inj	juries in the past –			
3. Please list any medicines you n	may be sensitive of allergic to and your re	action –		
Please list any medication you are currently taking –				

BP:

Uninalysis:

Weight:

Height:

Family History -

5. Have any close relatives (parents or siblings) suffered from the following?

Angina or Heart Attack	Cancer
Stroke	Asthma
Diabetes	Epilepsy
High Blood Pressure	Hypothyroidism

Please Detail - e.g. relationship and age of onset

Social History -

7.

6. How much alcohol do you consume in a week?

Pints	Per week	
Spirits	Glasses	
Wine	Glasses	

Do you currently smoke?

	If yes, would you be in support with stopping			Yes	No		(please circle))
	If no, have you ever sr	noked?		Yes	No		(please circle))
	(Please	e ask our Pra	ctice Nu	ırse for mo	re inform	ation.)		
8.	How much exercise do you take? (e circle)				
	Little or None	Light	Mode	ate	Vig	orous		
9.	Do you have a carer?			Yes	No		(please circle))
	If so, Who?			Phone No	ɔ :			
10.	Female Patients only -	_						
	Date of last smear tes	t –		Result –				
	Coil in situ			Yes	No	(plea	ase circle)	
11.	Obstetric History –							
	Delivery type –			Any Prob	lems? –			

Yes

No

(please circle)

12. Male Patients Only -

If you would like any information on Mens Health, this can be discussed at your New Patient appointment with the Practice Nurse.

New Patient Questionnaire

What is your Ethnic Group?

Please tick the box which best describes your ethnic group or background – Thank you.

Α	White				
		Scottish English Welsh Northern Irish Any other white ethnic grou	up, ple	British Irish Polish Gypsy/ Traveller ase write in	
В					
		Any mixed or multiple ethn	ic grou	р	
C Asian, Asian Scottish or Asian					
		Pakistani, Pakistani Scottis Indian, Indian Scottish or Ir Chinese, Chinese Scottish Other, Please write in	ndian E or Chi	British nese British	
D	Africa	n, Caribbean or Black			
		African, African Scottish or Caribbean, Caribbean Sco Black, Black Scottish or Bla Other, please write in	ttish or ack Bri	Caribbean British tish	
E Other Ethnic Group					
		Arab Other, please write in			
	If you	do not wish to give this i	nforma	ation, please tick here	