NEW PATIENT HEALTH QUESTIONNAIRE
GILLBRAE MEDICAL PRACTICE, GILLBRAE ROAD, DUMFRIES.

TELEPHONE: 01387 246282 **eMail : dg.gillbraemedicalpractice@nhs.scot**

Date and Time of Appointment: ……..

Surname	**First Names**
Date of Birth	**Telephone: Home:** **Work:** **Mobile:** **Email:** **Do you consent to us use text messaging or email to contact you e.g. appt reminders?** **Yes ☐ No ☒**
Next of Kin: **Telephone number:**	**Occupation:** **Marital status: Single/Married/Co-habiting/Separated/Divorced/Widowed/ Civil Partnership**

YOUR HEALTH

What is your height: …….. your weight ……

Have you ever suffered from any of the following:

Condition	***Please tick (√)***	***Details***
Asthma	☐	
Diabetes	☐	
Epilepsy	☐	Do you have seizures or fits? Yes/No If so, when was your last seizure?
Blackout/faints	☐	
Blindness/glaucoma	☐	
High blood pressure	☐	
Thyroid problems	☐	
Stroke	☐	
Nervous/mental breakdown	☐	
Cancer	☐	
Heart attack	☐	
Angina	☐	

Other Significant illnesses, disability or operations

Have your parents or brothers and sisters suffered from any of the above, or an inherited disease?	YES ☐ NO ☐ If yes, please state relationship and condition

Medication

Are you currently taking any tablets, medicine or injections? YES ☐ NO ▣

If yes, please give details below or attach a right side of a current prescription to this form

Allergies

Have you any allergies to medicines or to anything else? YES ☐ NO ☐

If Yes, please give details

Female patients only – Please tick or complete/delete appropriate sections

I currently have/have previously had/a coil	YES ☐ NO ☐
This was fitted/removed in	Date:
Are you taking the oral contraceptive pill or using the Depo injection or implant at present?	YES ☐ NO ▣ If yes, which one ……..
My last cervical smear was on (date)	Where was the smear taken? The result was: ……..
I have never had a smear	YES ☐ NO ☐
I do not want a smear	YES ☐ NO ☐ (***Please discuss with Doctor/nurse)***
Have you ever had a mammogram?	YES ☐ NO ☐
	If yes, when?
Have you had a hysterectomy?	YES ☐ NO ☐
	If yes, when?
Are you taking HRT (Hormone replacement therapy)	YES ☐ NO ☐
	If yes, which one?
Have you ever been pregnant?	YES ☐ NO ☐
How many pregnancies have you had?	
Have any ended in miscarriage, stillbirth, difficult delivery or Caesarean section?	YES ☐ NO ☐

Lifestyle

	Please tick (√)	Comments
Diet		
My diet is varied and balanced	☐	
I am on a special diet for medical reasons	☐	
I am on a slimming diet	☐	
I am a vegetarian/Vegan	☐	
Smoking		
I have never smoked	☐	
I used to smoke		
Cigarettes	☐	
Cigars	☐	
Pipe tobacco	☐	
I have given up smoking	☐	Please state when:
I currently smoke		Please state below how much you smoke?
Cigarettes	☐	
Cigars	☐	
Pipe tobacco	☐	
Would you like advice and help to stop smoking	YES ☐ NO ☐	
Drinking		

MEN: How often do you have EIGHT or more drinks on one occasion? WOMEN: How often do you have SIX or more drinks on one occasion? **(1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits)**	**0 Never**	**1 Less than monthly**	**2 Monthly**	**3 Weekly**	**4 Daily**
	☐	☐	☐	☐	☐
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☒	☐	☐
How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☒	☐

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	0 Never	2 Yes, on one occasion	4 Yes, on more than one occasion
	☐	☐	☐

Exercise	
I take regular exercise	YES ☐ NO ☐
	If yes, how much per week?
Blood Pressure	
Have you had your blood pressure taken within the last 5 years?	YES ☐ NO ☐

Vaccinations

Are your childhood vaccinations up to date? YES ☐ NO ☐
(If no, please discuss with doctor/nurse)

Ethnic Origin

Choose ONE section from A to E, and then tick the appropriate box to indicate your cultural background

		Please tick (√)	
A. White	Scottish	☐	
	Other British	☐	
	Irish	☐	
	Other	☐	Please specify:
B. Mixed			Please specify:
C. Asian, Asian Scottish or Asian British	Indian	☐	
	Pakistani	☐	
	Bangladeshi	☐	
	Chinese	☐	
	Other Asian	☐	Please specify:
D. Black, Black Scottish or Black British	Caribbean	☐	
	African	☐	
	Other Black	☐	Please specify:
E. Other Ethnic background			Please specify:
F. Other	Prefer not to disclose	☐	

What is your main Language	
If not English, do you require a translator?	YES ☐ NO ☐

Should you wish to disclose your sexual orientation please do so here.	

CARERS:
Do you, without payment, provide help and support to a partner, child, relative, friend or neighbour, who could not manage without your help? This could be due to age, physical or mental illness, addiction or disability. YES ☐ NO ☐

Thank you for completing this form. All information given is treated as confidential