

NEW PATIENT QUESTIONNAIRE

Drumnadrochit Medical Practice

We would be grateful if you could complete this questionnaire.

It will help us to help you until your records arrive from your previous doctor.

Today's date		
Surname		First name(s)
Date of birth		
Address		
Postcode		
Telephone / Mobile no.		
Name of previous GP		
Address of previous GP		
Past medical history		
Current medical problems		
Current medications		
Allergies / hypersensitivities		
Family history		
<i>Is there a history of the following conditions in your immediate family?</i>		
Condition	Relationship	Age of onset (approximate)
Asthma		
Diabetes mellitus		
High blood pressure		
Heart attack		
Stroke		
Others ...		
<i>For adults</i>		
Do you smoke?	Cigarettes / pipe? How much?	
Do you drink alcohol?	Units per week	
Weight	Height	
Date of last tetanus vaccination		
<i>For women</i>		
Number of pregnancies	Number of children	
Date of last cervical smear		
Contraception		