Inverkeithing Medical Group

**New Patient Questionnaire**

**Please answer all questions as fully as possible and return your form to the GP Reception Desk. If there is not enough room on the form for your needs, please add comments on a separate sheet.**

***Please note that it is the Practice policy that no-one can be registered and therefore receive full services from this Practice until a completed questionnaire has been handed in. It is our policy to offer a health check to new patients. Please arrange this with Reception.***

Use BLOCK CAPITALS in all cases

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| Surname: | Forename(s): |
| First Language: | Translator Required: Yes / No |
| Have you ever been registered with Inverkeithing Medical Group (either as a permanent or temporary patient) before? Yes No |
| Please provide the name, telephone number, address and relationship of your next of kin |  |

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| Do you wish to receive SMS text reminders for appointments and invites for medical reviewsMobile Number: |  Yes No |
| Patient Access (online repeat medication ordering and appointment booking)\*Patients aged 16+ ONLY\* | If you are interested in registering for this service, please either speak to reception staff or visit our practice website at [www.inverkeithingmedicalgroup.scot.nhs.uk](http://www.inverkeithingmedicalgroup.scot.nhs.uk) |
| **Smoking Status**Current Smoker: Yes/NoIf YES, how many per day?.................Ex-smoker: Yes/No When did you stop?.......................... Never Smoked | **Alcohol Consumption**Do you drink alcohol? Yes/NoIf Yes, how much per week(Approx 1 pint of beer is 2 units, a large glass of wine is 2 units, a double “short” is 2 units)Number of units of alcohol consumed per week:**…………………………………………………………** |

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| --- | --- |
| What is your height (in cm) |  |
| What is your weight (in kg) |  |

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| **For people eligible for cervical smears and breast screening only**When was your last cervical smear test – for females and people with a cervix aged 25 to 64?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_When did you last attend breast screening – for females aged between 50 and 70 every 3 years\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Relevant Family History: Please tick relevant statements | Heart Disease: No Family history of heart disease History of heart disease under 60 years  History of heart disease over 60 years  History of Heart AttacksDiabetes: No family History of diabetes  Family History of diabetes Family History of diabetes in 1st degree  relative (e.g.Parents, brothers,sisters) |

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| Do you have any allergies? |

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| Are you an unpaid carer? Yes NoIf yes, who do you care for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have a carer? Yes NoIf Yes, please provide their name and address below |

If you take medication, please ensure you hand in an **official list** (please do not write them on this form) of the medicine you receive ensuring you do this 7-10 days before you are due to run out.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_