Links Medical Practice

City Hospital, Park Road
Aberdeen, AB24 5AU
Tel: 0345 337 6340

Office Use Only
Nurse: ____________
Appt Date: ____________
Appt Time: ____________
Patient Accepted Yes/No

New Patient Medical Questionnaire

PERSONAL DETAILS – Our preferred method of contact is by email or mobile text please tick if you are happy to be contacted by email: ☐ **mobile** : ☐

Full Name: ______________________________
Date of Birth: ______________________________
Address: ______________________________
______________________________ Post Code: ______________
Home Tel No: ______________________________ Mobile No: ______________________________
Email Address: _

Ethnic Group:

White Scottish	☐	Pakistani	☐
Other White British Ethnic	☐	Bangladeshi	☐
Other Ethnic Mixed Origin	☐	Black Caribbean	☐
White Irish	☐	Black African	☐
Other White Ethnic Group	☐	Other Black Ethnic Group	☐
Chinese	☐	Arab	☐
Indian	☐	Other ethnic group (please state)	

____

Place of Birth: ______________________________ Marital Status: ______________________________
Other Household Members: ______________________________
Occupation & Employer: ______________________________
Next of Kin: ______________________________
(please state name, address, contact no.)
Do you require an Interpreter: YES ☐ NO ☐ If YES please state which language……………..

DETAILS OF PREVIOUS DOCTOR

GP Name: ______________________________
GP Address: ______________________________
Your address when registered with that Doctor: ______________________________

***Please tick if you are willing for your basic health information to be shared electronically with the hospital and Out of Hours Service - Yes* ☐ *No* ☐**

MEDICAL HISTORY

Any serious illnesses or operations? (please give details) ______________________________
____
____

What medicines do you use regularly? (ATTACH REPEAT MEDICATION FORM FROM PREVIOUS PRACTICE)
(please give details)

	Drug Name	***Dose***	***Frequency***
Example:	***Aspirin***	***75mg***	***Once Daily***

1 ______________________________

2 ______________________________

3 ______________________________

4 ______________________________

5 ______________________________

6 ______________________________

7 ______________________________

8 ______________________________

Blood Pressure Reading

Systolic ☐

Diastolic ☐

LINKS MEDICAL PRACTICE – HEALTH QUESTIONNAIRE

1. **Do you have any allergies? (please give details):**

   ____

2. Do any illnesses occur more commonly in your family, for example: Heart Disease under the age of 60 (please give details)

   ____

3. Have your parents, brothers or sisters had any of the following?

   Heart Attack (<u>under</u> age of 60) □ Diabetes □ Stroke □

   Heart Attack (<u>over</u> age of 60) □ High Blood Pressure □

   Angina □

4. Do you smoke? Yes/No

   Have you ever smoked? ______

   How many do/did you smoke per day? _____

   How old were you when you started smoking? ______

   When did you stop smoking? __________________

   Have you thought about stopping smoking? Yes/No

   Are you aware that both the Pharmacist and the GP can help you stop? Yes/No

5. Do you drink alcohol? Yes/No

   If yes how many units per week __________________

6. Do you use illegal drugs? Yes/No
7. Are you a carer? Yes/No

   Do you look after someone on a regular basis? Yes/No

   Who do you look after? i.e. wife, husband etc ____________________________

   Does someone look after you on a regular basis? Yes/No

8. Have you completed the Bowel Screening Kit? Yes/No

If yes, when? Month ______ Year ______

9. Height _____________ Weight ____________