# NEW PATIENT QUESTIONNAIRE

PLEASE COMPLETE USING BLOCK CAPITALS AND IN BLACK INK

**DATE** …….

## PERSONAL DETAILS

Surname……

Forename……

Date of birth: Day……. Month…….…. Year……

Edinburgh Address (***Must include flat number***)

……

……

Postcode……Telephone……..

Mobile…….Email……

**Are you an immigrant?** - YES/NO

**Gender** Male / Female (please circle)

**How long will you be studying in Edinburgh.....**

**Matriculation number…… (University e-mail address)**

## NEXT OF KIN/EMERGENCY CONTACT

Name……

Address……

……

Telephone……

## SMOKING STATUS

Do you smoke ? YES / NEVER / EX-SMOKER ( please circle)
Do you use electronic cigarettes or vape ? YES/NO (please circle)

## MEDICAL HISTORY

**1. ALLERGIES**

Do you have any allergies to **drugs or medicines**? YES/NO
If 'YES' please list……..……
…….
Do you have to carry an **adrenaline pen** for any allergies? YES/NO
If 'YES' please
list…….
……..

**2. Do you CURRENTLY suffer from, or are you receiving treatment for any of the following conditions? Please circle if YES.**

| | |
|---|---|
| ASTHMA | THYROID DISEASE |
| CANCER | HEART DISEASE |
| COELIAC DISEASE | EPILEPSY |
| DIABETES | HIGH BLOOD PRESSURE |
| SCHIZOPHRENIA | |

*(ADMIN - IF CIRCLED THE PATIENT MUST SEE NURSE ON 4$^{TH}$ FLOOR)*

**3. PLEASE LIST ANY OTHER SIGNIFICANT HEALTH PROBLEMS OR OPERATIONS**

DATE DIAGNOSIS
…….
……..……
……..……
……..

**4. FEMALES ONLY**

Have you ever had a cervical smear test? YES /NO
If YES, date and result of last test:
Date……
Result……
Was this test done in the UK? YES/ NO
If NO, which country…….

Have you ever had an abnormal smear test ? YES / NO
*(ADMIN - IF YES TO THIS, PASS FORM ONLY TO LAURA MACKENZIE )*

**5. CARERS**

Do you act as a regular carer for anyone else? YES / NO
*(ADMIN - IF YES PASS PATIENT DETAILS TO DR RICHARDSON)*

## ETHNICITY

What is your ethnic group? Choose **ONE** section **A to C** then tick the appropriate box to indicate your ethnic group. If you prefer not to answer then tick the box at the bottom of the page.

| **A: White** | **B: Black** | **C: Other ethnic group** |
|---|---|---|
| [ ] British<br>[ ] Irish<br>[ ] Scottish<br>[ ] Any other white background,<br><br>please state<br>…… | [ ] Black Caribbean<br>[ ] Black African<br>[ ] Black, other, non-mixed origin<br>[ ] Black British<br>[ ] Black West Indian<br>[ ] Black Guyana<br>[ ] Black North African<br>[ ] Black Arab<br>[ ] Black Iranian<br>[ ] Black – other African country<br>[ ] Black East African Asian<br>[ ] Black Indo-Caribbean<br>[ ] Black Indian sub-continent<br>[ ] Black – other Asian<br>[ ] Black – other, mixed | [ ] Indian<br>[ ] Pakistani<br>[ ] Bangladeshi<br>[ ] Chinese<br>[ ] Greek<br>[ ] Greek Cypriot<br>[ ] Turkish<br>[ ] Turkish Cypriot<br>[ ] Other European, please state……<br>[ ] Irish traveller<br>[ ] Other ethnic group<br>[ ] Traveller – gypsy<br>[ ] Arab |

[ ] **Do not wish to answer**

## CONSENT

We sometimes need to share your clinical information held in the Practice with staff in the Out of Hours service, the hospital and the ambulance service. This is to ensure they are fully aware of your medical history and any suggestions we have for your care in the eventuality you become unwell in the form of a care plan. **If you consent to this then please sign below**

**Signed .....**

By providing your contact details ***you are consenting*** to the Practice contacting you by either email or text**.** If you do not wish to be contacted by email or text then please write **NO** in this box.

July 2016