New Patient Health Questionnaire

Welcome to Murrayfield Medical Practice. You can find out more information about us from our website or in our Practice leaflet.

To help us get to know you, please complete this questionnaire as fully as possible. It gives the practice valuable information while your records are being retrieved from your previous doctor.

TITLE:		**FIRST NAME:**			
SURNAME:					
DATE OF BIRTH:		**Male** ☐ **Female** ☐ (please tick)			
MARITAL STATUS:					
ADDRESS (incl flat no):		**WHO ELSE LIVES IN THIS HOUSEHOLD?**	Boarding House Fellow students and houseparents (guardians)		
Houldsworth House 15 Ravelston Park Edinburgh EH4 3DX.		**ARE YOU A CARER FOR SOMEONE?** **If yes, please specify:**	**YES** ☐ **NO** ☐ (please tick)		
HOME TEL:	0131 311 8015	**WORK TEL:**		**MOBILE TEL:**	
NEXT OF KIN: (Name, Address, Tel No.)					
ARE YOU HAPPY TO HAVE MESSAGES LEFT ON THE FOLLOWING NUMBERS?	**HOME TEL:**	**YES** ☐ **NO** ☐ (please tick)			
	MOBILE TEL	**YES** ☐ **NO** ☐ (please tick)			
We offer a text reminder service for appointments - do you consent to text reminders?		**YES** ☐ **NO** ☐ **(please tick)**			
OCCUPATION:	Student				
ARE YOU CURRENTLY A STUDENT?	**YES** ☒ **NO** ☐	**IF YES, WHERE?**	St. George's School, Edinburgh.		
WHY DID YOU CHOOSE OUR PRACTICE?					
I live locally to the practice.					

PLEASE TELL US YOUR HEIGHT AND WEIGHT			
Height:		**Weight:**	

SMOKING HABIT				
Are you a current smoker?	**If Yes**		**If No**	
YES ☐ **NO** ☐ (please tick)	**No. Cigarettes per day?**		**Have you ever smoked?**	
	No. Cigars per day?		**If yes, what year did you stop?**	
	Pipe tobacco per week? (oz / grams)		**How many *did* you smoke per day?**	
	Would you like help to stop?	**YES** ☐ **NO** ☐		

ALCOHOL INTAKE	
Do you drink alcohol?	**YES** ☐ **NO** ☐ (please tick)
If Yes: Wines / Spirits: units per week	
Beer: units per week	
1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer	

EXERCISE HABIT	
Do you take regular exercise?	**YES** ☐ **NO** ☐ (please tick)
If Yes: What sort : (eg. Tennis, walking)?	
For how long at any one time?	
How many times weekly?	

MEDICATION	
ARE YOU ON ANY REGULAR MEDICATION? (including the contraceptive pill)	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state name and dose: (Please note you will be required to see the doctor for a first repeat prescription to be issued)	
ARE YOU ALLERGIC TO ANY MEDICINES OR HAVE ANY ALLERGIES?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please list details:	

WOMEN ONLY					
Date of Last Smear?		**What was the Result?**		**Where was it taken?**	
No. of Pregnancies?		**No. of Children?**		**Are you pregnant now?**	

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
If Asthmatic, have you used your inhaler in past 12 months?	**YES** ☐ **NO** ☐		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had :

	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY

Has a parent or sibling suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐
If Yes, Please give details:

Please give details of the current state of your family's health:

	Age	**State of Health**	**Age at death**	**Cause of Death**
Father				
Mother				
Sibling(s)				