Hermitage Medical Practice

NEW PATIENT QUESTIONNAIRE
5/6 HERMITAGE TERRACE
EDINBURGH
EH10 4RP

TEL NO 0131 447 6277 / 3344
FAX 0131 447 9866
WEBSITE:-
www.hermitagemedical.co.uk

PERSONAL DETAILS

Title. MR/MRS/MISS/MS/OTHER……..

Name …….

Address …….

…….

Postcode …….

Tel no……Mob no ……..

- **Please circle if you give consent for SMS communication to be made via your mobile number Yes/No.**

Email.....

Date of Birth …….

Marital Status (Please Circle)

Single/Married/Divorced/Widowed/Partner

Nationality ……

Ethnic Origin. (Please Circle)

1. **White**
2. **Mixed /**
3. **Asian or Asian British**
4. **Black or Black British**
5. **Chinese or Other Ethnic Group**
6. **Prefer not to say**

Can you speak good English?……(If not we can organise Interpretation Service, with notice)

Occupation……..

LIFESTYLE

Height ……..

Weight ……

Have you ever Smoked? YES/ NO
Do you currently Smoke? YES/ NO

If YES How Many? ……

Do You Drink Alcohol? YES/ NO

If YES How Much Per Week?……..Units (1 unit = ½ pint beer, 1 glass wine, 1 measure of spirits)

Do You Take Regular Exercise? (Please Circle)
None/ Some/ Active

Diet Type (Please Circle)
Normal/Low Fat/Vegetarian/Other

…….

NEXT OF KIN

Name ……

Tel no …….

Relationship to Patient …….

Do you act as a carer for a friend or relative?…….

MEDICAL HISTORY

Do You Take Any Regular Medication? Please List below any repeat medication or attach a repeat order form of your prescriptions listing your repeat medication

……..

…….

……..

Do you suffer from any Allergies?

……

Please give brief description of any operations, significant illnesses or injuries you have had and the year it occurred.

……

…….

Have your Parents or Siblings had a serious illness(i.e heart disease, stroke, High Blood Pressure or Cancer)?

……..

IMMUNISATIONS

Please list vaccinations (parents please bring children's record book)

VACCINE	DATE
MMR	…….
TETANUS BOOSTER	…….
POLIO BOOST	……
HEP A	……
HEP B	…….
MENINGITIS C	…….
BCG	…….
TYPHOID	……..
YELLOW FEVER	……
OTHER ……..	……..
…….	…….

Are you between 16 to 25 years and have had the following vaccinations

		Date
MMR	Yes / No	.....
MENACWY	Yes / No	.....
HPV (Females only)	Yes / No	.....

FEMALE HEALTH

When and where was your last cervical smear taken?

Date …….. GP/OTHER …….

Have you ever had an abnormal smear? YES / NO

If YES when? ……

How many pregnancies have you had? ……..

Are you taking oral contraceptive? YES / NO

Do you have an IUCD fitted? YES / NO