Daisy Villa Surgery
St Margaret's Hope
Orkney
KW17 2SN

New Patient Questionnaire

Title: ..... Surname: ..... Forename(s): .....

Preferred name: ..... Ethnicity..... Date of Birth: .....

Address: .....

Post Code: ..... Town of Birth.....

Telephone No: ..... Mobile No:..... E-mail address:.....

Please tick boxes ☑ as appropriate.

Medical History

Have you suffered with any of the following?

TB	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Heart Problems:		
Angina	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐
Heart Murmurs	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
If 'Yes' Please specify:		
.....		
Jaundice	Yes ☐	No ☐

Any other *major* illnesses? (Please specify)

- .....
- .....

Please list any operations:

- ..... Year: .....
- ..... Year: .....
- ..... Year: .....
- ..... Year: .....
- ..... Year: .....

Treatment History

Are you on regular medication? Yes ☐ No ☐

If 'Yes', please list the medication below and ensure you bring it with you to your new patient check:

- .....
- .....
- .....
- .....
- .....

Are you allergic to any drugs/vaccines? Yes ☐ No ☐

If 'Yes', please list them below:

- .....
- .....

Any other allergies? Yes ☐ No ☐

If 'Yes', please list them below:

- .....
- .....

Women

Have you ever had a smear? Yes ☐ No ☐

If 'Yes', approximate date of the last one:

.....

Please Turn Over

Have you ever had a mammogram? Yes ☐ No ☐

If 'Yes', approximate date of the last one:

.....

Are you pregnant? Yes ☐ No ☐

Do you use contraception? Yes ☐ No ☐

If 'Yes' please indicate which type:

Pill	☐
Coil	☐
Sheath	☐
Cap	☐
Sterilised	☐
Other	☐

If 'Other' please specify:.....

Family History

Have your parents, brothers or sisters suffered with any of the following?

Asthma	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Heart problems before the age of 60	Yes ☐	No ☐
Heart problems after the age of 60	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Glaucoma	Yes ☐	No ☐
Cancer:		
Breast	Yes ☐	No ☐
Large bowel	Yes ☐	No ☐
Other	Yes ☐	No ☐

If "Yes" please specify which relative .....

Any other *major* illnesses in the family: (Please list)

- .....
- .....

Social History

Marital status:

Single	☐
Married	☐
Other	☐

If 'Other' please specify:.....

Number of children:

Boys .....

Girls .....

Occupation/Trade

Please specify main occupation, full time (FT), or part time(PT)

- ..... FT ☐ PT ☐

Lifestyle

Do you smoke? Yes ☐ No ☐

If 'Yes', please indicate:

No of Cigarettes per day: .....

No of Cigars per day: .....

Pipe or roll ups, ozs per week: .....

If you smoked in the past please give the year when you stopped: .....

How many units of alcohol do you drink in an average week? .....

(N.B. 1 unit of alcohol = ½ pt beer, or 1 glass of wine, or 1 pub measure of spirits)

Do you exercise regularly: (Please tick one box)

Never	☐
Lightly	☐
Moderately	☐
Vigorously	☐

Thank you for completing this form.

Please remember to bring the following to your new patient check:

- This form; ☐
- A specimen of your urine in a clean container; ☐
- Bottles and boxes of the medication you are taking. ☐

Signed: ..... Date: .....