GLEBE MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

Surname: ……………………………….. Forenames: ……………………….…………………………….

Date of Birth: ……………………………………………………….

Present Address: ………………………………………………………………………………………

……………………………………………………………………………………………………….

Post Code: ………………… Mobile.: ………………………. Home tel: ……………………….

Previous Address: ……………………………………………………………………………….….

……………………………………………………………………………………………………….

Previous GP (Name and Address)

………………………………………………………………………………………………………

………………………………………………………………………………………………………

We send text messages to patients to remind them of appointments, invite them for annual reviews and as a means of contact when we need to speak to them.

Please indicate if you wish to be contacted by text message (please circle) **YES** **NO**

Marital Status (Please circle)

Single Married Separated Divorced Widowed

Next of Kin: **Name**: ………………………………………….. **Relationship to you:** ………………………

Tel. No. (Work) …………………………………. (Home) ………………………………………………

Address: ………………………………………………………………….……………………………..

Please indicate where you would like any prescriptions to be sent:

BOOTS ABBEYGREEN PHARMACY KIRKMUIRHILL COALBURN

Are you a carer (please circle) **YES** **NO** If yes, who do you care for? …………………………….

Do you have a carer (please circle) **YES** **NO**

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.
Please tick only one section.

Ethnic Origin	X	Office Use
White British		9S10.
White Irish		9S11.
Other white ethnic group		9S12.
White Scottish		9S13.
Other white British ethnic group		9S14.
Other ethnic, mixed origin (please state)		9SB..
Indian		9S6..
Pakistani		9S7..
Chinese		9S9..
Other Asian ethnic group		9SH..
Black Caribbean		9S2..
Black African		9S3..
Other black ethnic group		9SG..
Other ethnic group		9SJ..
Ethnic group not recorded		9SE..
Ethnic group – patient refused		9SD..
INTERPRETER NEEDS		
Interpreter needed – British Sign Language		9NUw.
Translator/Interpreter		O41E

Others at Present Address:

Name	Age	Relationship to you
....	…….	………………………………………
…………………………………….	…….	………………………………………
…………………………………….	…….	………………………………………
…………………………………….	…….	………………………………………

Past Medical History:
(e.g. Serious illness, hospital admissions, operations)

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Do you have any drug allergies/side effects from medication?

…………………………………………………………………………..…………………..…………..……….

Present Medication: (Prescribed): **If you are prescribed REPEAT medication it is IMPORTANT that you inform us of the Drug Name, Dose and Amount taken. Failure to do so may result in a delay when you request your medication. If you have a tear off slip with your medication from your previous practice please attach with this form.**

Drug Name	**Dose**	**Amount Taken**
(Example)		
Aspirin Dispersible	*75mg*	*1 daily*
…………………………………	……….	…………….
…………………………………	……….	…………….
…………………………………	……….	…………….
…………………………………	……….	…………….
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…………………………………	……….	…………….
…………………………………	……….	…………….
…………………………………	……….	…………….
…………………………………	……….	…………….
…………………………………	……….	…………….

Smoking History: Never Smoked

Ex-Smoker Date Started: [ ] Date Stopped: [ ]

Amount Smoked . [ ] Cigarettes Pipe Cigars

Alcohol Intake: [ ] Units/Week

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

DOCUMENTS REQUIRED FOR REGISTRATION

Photo ID

Passport
Driving Licence
Bus Pass
Blue Badge
Alternatively Medical card or Birth Certificate (patients without Photo ID)

Proof of Residency

Utility bill
Bank statement
Rental agreement

If you are registering from abroad

Passport
Work Permit
Self Employed - Invoices or receipts for your work.
Student Visa and a letter from your college or university stating when your course starts and how long it lasts.