Pathhead Medical Centre
New Patient Questionnaire

Have you been registered with us before? YES/NO

Please complete all questions on both sides

Full name: .....Preferred name: .....

Date of birth: .....

Telephone Number: .....Mobile Number: .....

Email Address: .....

Status: Single Married Divorced Widowed Co-habiting Civil Partnership

Next of kin name……..

Relationship of Next of Kin……

Contact details of Next of Kin……

Gender preference details, please include if you would like us to use a specific pronoun ……...

Ethnic origin:

Scottish	Polish	Other Asian Ethnic Group
English	Other Ethnic Group	Black African
Welsh	Other mixed Ethnic Group	Black Caribbean
Northern Irish	Pakistani	Black British
British	Indian	Other Black Ethnic Group
Irish	Bangladeshi	
Traveller	Chinese	

Height: .....Weight: .....

Are you a Carer? YES/NO Are you being cared for? YES/NO

Smoking Status - please circle one:

Never Smoked/ Ex-Smoker /E-Cigarette /Current Smoker - how many do you smoke per day.....

Do you have any Allergies? .....

Do you drink alcohol? YES/NO If YES How many units per week? .....

Do you need an interpreter? YES/NO If YES Which language? .....

Family History – please circle if any of these diseases run in your family

Diabetes	Osteoporosis
Hypertension	Thyroid Disorder

Heart Disease
Heart Attack
Stroke
Cancer (please state type)
Other:

Current Medications

Please list below any medications you take regularly, either prescribed by a GP/Hospital/Clinic or bought at a pharmacy.

Medication	Dose	How often

Medical History – Please give details of any past operations or illnesses requiring Hospital or GP treatment. Also any ongoing conditions.

Date	Operation/Illness	Comments

Sharing Your Contact Details

Please help us to keep our records up to date by providing us with details of your mobile number and email address if they change. We may currently use your email address to contact you about your prescriptions. In the future we may send text reminders for appointments. You may withdraw consent to either or both of these at any time by contacting reception.

Do you consent to contact by text? YES/NO

Do you consent to contact by email? YES/NO

Children and Young People Aged 12-16 years Only

Children from the age of 12 are able to make decisions on their own regarding how their personal information is processed, unless the GP considers otherwise. We will ask for consent before disclosing medical information to their parent or guardian.

If you are aged 12-16 years

Do you consent to information about your health being given to your parent or guardian?
YES/NO

Emergency Care Summary (ECS)

Emergency care information such as your name, date of birth, the name of your GP, any medicines which your GP has prescribed, any medicines you are allergic to or react badly to, is shared with emergency and hospital services as this might be important if you need urgent medical care when the GP surgery is closed.

Do you consent to sharing your information with emergency and hospital services?
YES/NO

Scottish Primary Care Information Resource (SPIRE)

NHS Scotland uses information from GP patient records to help plan and improve health and care services in Scotland. It uses information from GP practices all over Scotland in a safe and secure way. For further information about SPIRE contact NHS Inform on 0800 22 44 88 or visit http://spire.scot/

Do you consent to your information being shared with SPIRE? YES/NO