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| **TEMPLEHILL SURGERY TROON**  **NEW PATIENT HEALTH RECORD** |
| *You have just applied to join our list and it may be some months before your records reach us. This may of course be important and the absence of these records may impair the service we wish to give you. It is therefore in the best interests of both yourself and your doctor that you complete this questionnaire FOR EACH MEMBER OF YOUR FAMILY.*  PLEASE NOTE: The completion of this document does not mean that you have been registered with this Practice as a patient. Such registration only occurs when your Application to Register is handed over. |

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| **PERSONAL DETAILS** | | |  | | | | | | | | | | | | |
| SURNAME: | |  | | | FORENAME: | | |  | | DATE OF BIRTH: | | | |  | |
| MARITAL STATUS: | | |  | | | | | | SEX: | |  | | | | |
| ADDRESS: |  | | | | | | | | | | | POSTCODE: | | |  |
| TELEPHONE NUMBER: | | | |  | | | | EMAIL ADDRESS: | | | | |  | | |
| SURNAME AT BIRTH: | | |  | | | PLACE OF BIRTH | | |  | | TYPE OF HOUSING | | | |  |
| NEXT OF KIN (*with contact details*) | | | | | | |  | | | | | | | | |
| Named Carer for Patient (*if applicable*) | | | | | | |  | | | | | | | | |

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| **GENERAL HEALTH** |  | | | | | | |
| DO YOU SMOKE? | YES NO | | HAVE YOU EVER SMOKED? | | | YES NO | |
|  | | | IF YES HOW MANY PER DAY? | | |  | |
|  | | | IF YES DATE STOPPED | | |  | |
| HEIGHT |  | | WEIGHT | | |  | |
| DO YOU DRINK ALCOHOL? | | YES NO | | | IF YES HOW MANY UNITS PER WEEK? | |  |
| DIET (*mixed/vegetarian/other*) | | | |  | | | |

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| **MEDICAL HISTORY** | |  | | |
| ILLNESSES *(e.g. DIABETES/ASTHMA/HIGH BLOOD PRESSURE etc.)* | | | OPERATIONS *(e.g. TONSILECTOMY/ HYSTERECTOMY/VASECTOMY etc.)* | |
| YEAR DIAGNOSED | DETAILS | | YEAR | DETAILS |
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| **MEDICATION** | *PLEASE GIVE DETAILS OF ANY MEDICATION AND DOSAGE AND BRING CONTAINERS/REPEAT LIST ALONG* |
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| **FAMILY MEDICAL HISTORY** | | *e.g. FATHER/MOTHER/BROTHER/SISTER/CHILDREN* | | | |
| **HEREDITARY DISEASES** | **RELATIONSHIP** | | **AGE** | **IF DECEASED, CAUSE OF DEATH** | **AGE WHEN DIED** |
| TUBERCULOSIS |  | |  |  |  |
| ASTHMA |  | |  |  |  |
| GLAUCOMA |  | |  |  |  |
| HEART DISEASE |  | |  |  |  |
| HIGH BLOOD PRESSURE |  | |  |  |  |
| KIDNEY DISEASE |  | |  |  |  |
| DIABETES |  | |  |  |  |
| OTHER: |  | |  |  |  |
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| **FEMALE HISTORY** | |  | | | | | | | | | |
| HOW MANY PREGNANCIES HAVE YOU HAD? | | | |  | | DATES | |  | | | |
| HAVE ANY OF THEM ENDED IN: | | | | IF YES WHICH ONE? | |  | | | | | |
| MISCARRAIGE | YES NO | | |  | |  | | | | | |
| STILLBIRTH | YES NO | | |  | |  | | | | | |
| DIFFICULT DELIVERY | YES NO | | |  | |  | | | | | |
| ARE YOU USING ANY FORM OF ORAL CONTRACEPTION? | | | | YES NO | | IF YES, FOR HOW LONG? | | | | |  |
| HAVE YOU HAD A CERVICAL SMEAR TEST? | | | YES NO | | IF YES, WHEN AND WHERE? | | | | |  | |
|  | | | IF NO, WOULD YOU LIKE ONE? | | | | YES NO | | | | |
| HAVE YOU EVER HAD BREAST SCREENING? | | | YES NO | | IF YES WHEN AND WHERE? | | | |  | | |

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| **FURTHER DETAILS** | *PLEASE GIVE DETAILS AS REQUESTED* |
| ANY DISABILITIES  (*e.g. blind/deaf/amputations etc*) |  |
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| ANY MAJOR SOCIAL PROBLEMS *(e.g. unsatisfactory housing/marital problems/disabled children)* |  |
|  |
| ANY ALLERGIES/SENSITIVITIES  *(e.g. Penicillin/Aspirin/Skin reaction etc.)* |  |
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| **IMMUNISATION/VACCINATION RECORD** | |  |
| **DETAILS** | **YEAR** | |
| POLIO TRIPLE |  | |
| TETANUS |  | |
| MMR |  | |
| BCG |  | |
| OTHER *(please state)* |  | |
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Templehill Surgery **Patient Questionnaire**

23 Templehill

Troon

KA10 6BQ

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| *This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your healthcare. Please ask a member of staff if you need more explanation.*  *Please could you complete one questionnaire for each member of the family registering with the Practice.* |

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| **Name** |  | **Date of Birth** | |  |
| Do you need an interpreter or sign language? | | Yes | | No |
| If you do need an interpreter what language do you speak? | | |  | |

**What is Your Ethnic Group?**

(Please indicate which best describes your ethnic group or background)

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| **White** |  | | | | | | | |
| Scottish | | | | | | | |  |
| English | | | | | | | |  |
| Welsh | | | | | | | |  |
| Northern Irish | | | | | | | |  |
| British | | | | | | | |  |
| Irish | | | | | | | |  |
| Gypsy/Traveller | | | | | | | |  |
| Polish | | | | | | | |  |
| Any other white ethnic group (please state) | | | | | |  | | |
|  | | | | | | | |  |
| **Mixed or Multiple Ethnic Groups** | | | | |  | | | |
| Any mixed or multiple ethnic groups | | | | | | | |  |
|  | | | | | | | |  |
| **Asian, Asian Scottish or Asian British** | | | | | | |  | |
| Pakistani, Pakistani Scottish or Pakistani British | | | | | | | |  |
| Indian, Indian Scottish or Indian British | | | | | | | |  |
| Bangladeshi, Bangladeshi Scottish or Bangladeshi British | | | | | | | |  |
| Chinese, Chinese Scottish or Chinese British | | | | | | | |  |
| Other (please state) | | | |  | | | | |
|  | | |  | | | | | |
| **African, Caribbean or Black** | | |  | | | | | |
| African, African Scottish or African British | | | | | | | |  |
| Caribbean, Caribbean Scottish or Caribbean British | | | | | | | |  |
| Black, Black Scottish or Black British | | | | | | | |  |
| Other (please state) | | | |  | | | | |
|  | | | |  | | | | |
| **Other Ethnic Group** | |  | | | | | | |
| Arab | | | | | | | |  |
| Other (please state) | | | |  | | | | |