**Main Street Aberfoyle Stirling**

**FK8 3UX**

Aberfoyle and Buchlyvie Medical Centre

**Drs Morrison and Cox** **Station Road Buchlyvie Stirling FK8 3NB**

**Telephone: 01877 382 421**

[**www.aberfoyle-buchlyviesurgeries.co.uk**](http://www.aberfoyle-buchlyviesurgeries.co.uk/)

**NEW PATIENT HEALTH QUESTIONNAIRE**

**Telephone: 01360 850 237**

Please complete this questionnaire as fully as possible

# Personal Details

Title

First Name

Surname

Date of Birth

Address

Telephone Number

Mobile Number

Email

Next of Kin (name and telephone number)

Relationship to you

What is your occupation?

# Ethnicity

I would describe my ethnicity as (please circle below)

White Scottish Indian African Other

White British Pakistani Black or Black Scottish

White Irish

Bangladeshi Other Asian Caribbean Other Ethnic Group Other White Chinese Any mixed

# Medical History

Please tell us about current conditions, past conditions and any operations including date

# Medication

Please list any medication that you are currently taking

Name Dose

# Allergies

Do you have any allergies? Yes/No

If so, please list

# Family History

Please list any illnesses that run in your family

|  |  |  |
| --- | --- | --- |
| Heart Disease | Yes / No | Relationship to you: |
| Diabetes | Yes / No | Relationship to you: |
| Stroke/TIA | Yes / No | Relationship to you: |
| Asthma | Yes / No | Relationship to you: |
| High Blood Pressure | Yes / No | Relationship to you: |
| Cancer  If yes, type | Yes/No | Relationship to you: |

# Lifestyle

Do you take regular exercise Yes/No

If yes, how often and type

Do you smoke Yes/No

If yes how many per day?

Do you drink alcohol Yes/No

If yes, how many units per week?

What is your height? What is your weight?

# Carers and Being Cared For

Do you care for someone? Yes/No

Do you have a carer? Yes/No

If yes, what is your relationship with the person being cared for/your carer

Is the person registered with this practice? Yes/No Name of person cared for

# For Women Only

When was your last cervical smear?

Which method of contraceptive, if any do

you use? How many pregnancies have you had Type of delivery