DRS RUDDELL CAMPBELL WARKE HAMILTON STEELE & McKEE

NEW PATIENT MEDICAL QUESTIONNAIRE

It is important that you complete both sides of the form in BLOCK CAPITAL LETTERS and tick √ as appropriate . This information is strictly confidential.

SURNAME	FIRST NAME (S)	TITLE (Please circle as appropriate)	DATE OF BIRTH	☐ MALE
		Mr / Ms / Mrs / Miss / Dr / Rev		☐ FEMALE

CURRENT ADDRESS ……

POSTCODE…… **Email address (please print)** ……

TEL NUMBER (Home) …… **(Mobile)**…… **(Work)**……

Consent for us to contact you by text YES / NO **Consent for us to contact you by email YES / NO**

Would you like to sign up to online script ordering (pin numbers will be sent by email) YES / NO

NEXT OF KIN / EMERGENCY CONTACT (circle appropriate)

Name …… **Relationship to you** ……

Address ……

Tel Number …… **Consent for your record to be discussed with this person YES / NO**

COUNTRY OF BIRTH	NATIONALITY	DATE ENTERED UK (if applicable)

Do you need an interpreter YES / NO **If yes what language**……..

PREVIOUS GP Name …… **Telephone no**……

Please provide a brief summary from your previous GP along with the completed registration documents.
Alternatively you can send it by email to reception.z00229@gp.hscni.net
*******Failure to do so may result in a delay with your registration*********

Have you ever been registered with any of the 7 GP Practice's in Lisburn Health Centre? YES / NO

If <u>YES</u> please state which Practice and when: ……..

Have you any family members registered with any of the 7 GP Practice's in Lisburn Health Centre? YES / NO

If <u>YES</u> please state which Practice: ……

CARERS	
<u>Are</u> you a Carer? YES/ NO If Yes, who do you care for?	**<u>Have</u>** you a Carer? YES / NO If yes, who is your Carer?

MEDICAL CONDITIONS Do you currently suffer from any of the following conditions? Please tick as appropriate

☐ Asthma	☐ Stroke
☐ COPD	☐ High blood pressure
☐ Cancer	☐ Tuberculosis
☐ Epilepsy	☐ Depression / Mental Health
☐ Hypothyroidism	☐ Kidney Disease
☐ Diabetes	☐ Any other significant illness, hospitalisation or previous surgery
☐ Heart Disease / Heart Failure	
☐ Atrial Fibrillation	(please specify)……

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Do you have a sensory impairment? YES / NO

Hearing Impairment [ ] Deaf [ ] Partially sighted [ ] Blind [ ]

Do you require a sign language interpreter? YES / NO

CURRENT MEDICATION

Are you taking any medication? YES/ NO If yes, please list drug name, strength and dose:

Name of chemist in Lisburn your wish <u>all</u> your prescriptions to be sent……

ALLERGIES **Do you have any allergies? YES / NO if yes, please state below**

FAMILY HISTORY (applies to parents/ brothers/sisters)

Medical Conditions	(tick)	**Details**
High blood pressure		
Stroke		
Heart disease (over 60 yrs)		
Heart disease (under 60 yrs)		
Asthma		
Diabetes		
Cancer		
Other		

Do you drink alcohol?

1. How often do you have a drink containing alcohol?
   - □ a. Never
   - □ b. Monthly or less
   - □ c. 2-4 times a month
   - □ d. 2-3 times a week
   - □ e. 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?
   - □ a. 1 or 2
   - □ b. 3 or 4
   - □ c. 5 or 6
   - □ d. 7 to 9
   - □ e. 10 or more
3. How often do you have six or more drinks on one occasion?
   - □ a. Never
   - □ b. Less than monthly
   - □ c. Monthly
   - □ d. Weekly
   - □ e. Daily or almost daily

Do you smoke?	□ YES (no per day) ……. pipe, cigars, cigarettes, e-cigarette etc	□ NO

Do you have any involvement with Social Services? YES / NO

This section is for women only	Date of last smear……Result ……. Any abnormal smear results? YES / NO

Signature _____ **Date**_____