Mistylaw Medical Practice: PATIENT QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care. We would be grateful if you could complete one for each family member within/joining the practice.

Name …….. DOB _ _ / _ _ / _ _

Do you need an interpreter or sign language support? ☐Yes ☐No

If you do need an interpreter what language do you speak?

Please state ……

What is your ethnic group?
Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background

A White
□ Scottish
□ English
□ Welsh
□ Northern Irish
□ British
□ Irish
□ Gypsy/Traveller
□ Polish
□ Any other white ethnic group, please write in ……..

B Mixed or multiple ethnic groups
□ Any mixed or multiple ethnic groups

C 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 write in…….

D African, Caribbean or Black
□ African, African Scottish or African British
□ Caribbean, Caribbean Scottish or Caribbean British
□ Black, Black Scottish or Black British
□ Other, please write in……

E Other ethnic group
□ Arab
□ Other, please write in……..

If you do not wish to give this information, please tick here ☐

NEW PATIENT INFORMATION CARD

Please complete both sides of this sheet

Date: _____

Title: Mr/Mrs/Miss/Ms/OTHER please state: _____

Surname: _____

First Name(s):_____

Address: _____

_____

Home Telephone Number: _____

Other Contact Number: _____

Email Address: _____

Marital Status: _____ **Date of Birth:**_____

Sex: _____ **Occupation:** _____

NEXT OF KIN: _____

TEL NO : _____

RELATIONSHIP: _____

When attending your New Health Check appointment with the Practise Nurse, please bring a urine sample in a silver top bottle available from reception.

General History

Have you had any serious illnesses or operations, x-rays or similar tests and when? _____

_____

_____

What medication are you taking? _____

_____

Have you any allergies to medicines or anything else? _____

_____

How much tobacco or cigarettes do you smoke? _____

How much alcohol do you consume per week?

Wine _____ **Beer** _____ **Spirits**_____

(one unit = 1 glass of wine or ½ pint of beer or small measure of spirits)

Do you exercise regularly?_____

Number of hours? _____

Height _____ metres **Weight** _____ Kg

FAMILY HISTORY **Please tick appropriate boxes**

Which of your blood relations have suffered from the following:

Heart attack	☐	_____	Cancer	☐	_____
Diabetes	☐	_____	High Blood Pressure	☐	_____
Asthma	☐	_____	Tuberculosis	☐	_____
Stroke	☐	_____	Other serious illness	☐	_____

VACCINATIONS **Which vaccinations have you had and when? (eg Holiday Vaccinations)**

_____

_____

_____

_____

CARERS

Do you look after someone or does someone look after you _____

FOR FEMALE PATIENTS ONLY

Have you had any children? **YES/NO** give ages _____

Have you had a miscarriage? **YES/NO** date _____

Have you had a termination of pregnancy? **YES/NO** date _____

Have you had a hysterectomy? **YES/NO** date _____

Which method of contraception are you using at present? _____

When was your last smear test? _____