New Patient Questionnaire

Bathgate Primary Care Centre

Welcome. Please help us by filling in this questionnaire as it may take some time for your previous medical records to reach us. The information you give will be used to provide you with good medical care.

Have you been a patient at the practice before ? Yes / No

Title:	Full name:
Date of Birth:	Address and Postcode:
Maiden Name:	
Next of Kin:	
Next of Kin address Tel No: Relationship:	Contact details: Landline: Mobile: Email: Please tick if relevant:: Military Veteran .....Ex Military.....
Country of Origin: Do you need an interpreter? If yes, what language?	Occupation .....

MEDICATION AND TREATMENT

Can you please bring a printed list or labels from your medication bottles along with you to your first appointment with a health care professional.

Do you have any allergies?,.....

LIFESTYLE

Do You smoke? **Yes / No** Do you Vape or use E-Cigarette? **Yes / No** If No have you ever smoked **Yes / No**

How many units* of alcohol do you drink per week? _____
If none, are you completely teetotal Yes / No *1 unit = 1 glass wine, 1 glass spirit or half pint of beer

Do you keep to a diet? _____ If yes, please give details _____

Do you undertake regular sport or exercise? _____

If yes, please give details and frequency _____

Height..... Weight.....

CONSENT TO TEXT MESSAGING

With your consent we will send reminders of pre-booked appointments you have with clinicians in the practice and other important information to your mobile phone.

I consent to receiving text messages regarding appointments and other information at the practice.

Mobile phone number_____

Signature _____Date_____

FAMILY HISTORY

Have any of your father/mother/sisters/brothers suffered from:

ASTHMA:_____Age_____ HIGH CHOLESTEROL _____Age_____

DIABETES:_____Age_____ HEART TROUBLE _____Age_____

CANCER:_____Age_____ STROKE_____Age_____

THYROID DISEASE:_____ EPILEPSY _____Age_____

HIGH BLOOD PRESSURE :_____ Age_____

FEMALE PATIENTS ONLY

When was your last cervical smear taken _____Where_____

Result_____

CARERS

Carers are people who look after a partner, husband or wife, son & daughter, relative or friend with a disability. Carer live with the person they care for, but many look after someone who lives independently. Carers are family members or friends who look after someone without financial reward.

ARE YOU A CARER : **YES/NO**

IF YES WHO DO YOU CARE FOR:

NAME:_____**D.O.B.** _____

ADDRESS:_____

Is the patient registered with this practice?

If yes, can we pass your information to Carer's of West Lothian? **YES/NO**

ETHNIC BACKGROUND

Choose ONE section from A to E, then tick the appropriate box to indicate your cultural background:

A **White** Scottish ☐ Other British ☐ Irish ☐

Any other White background (please specify)_____

B **Mixed** Any Mixed background (please specify)_____

C **Asian, Asian Scottish or Asian British**

Indian ☐ Pakistani ☐ Chinese ☐ Bangladeshi ☐

D **Black, Black Scottish or Black British** Caribbean ☐ African ☐

E **Other Ethnic background (Please specify)** _____