CORONATION ROAD
PETERCULTER
ABERDEEN
AB14 0RP
Tel. No. 01224 733535

Welcome to our Practice!

To enable us to provide you with appropriate healthcare, we would be grateful if you could complete the following questionnaire. You will then be asked to make an appointment with our nurse who will carry out a basic health screen. Patients who are on regular prescribed medication should make an appointment to see one of the doctors at the practice. Thank you for your co-operation.

Drs Harris, Owen, Howarth, McMain, Sudder and Ede

PERSONAL DETAILS

Title (Mr, Mrs, Miss, Ms, Dr etc) ....

Name ....

Address ....

....

....

Date of Birth ______

Nationality ______

Marital Status ______

Occupation

Tel. No.: Home Office

Which Ethnic Group do you belong to? You are not obliged to complete this section

☐ White ☐ Chinese ☐ Indian ☐ Bangladeshi ☐ Pakistani ☐ Black-African ☐ Black-Caribbean

☐ Other (Please State) ……………………………………

☐ I do not wish to give this information

Have you **ever** smoked cigarettes or tobacco? **YES** **NO** (Please circle)

If you have answered '**YES**' to the above question, please answer **either** a) or b) below:

a) How many cigarettes do you smoke in a day? .... (Please write in number)

Do you wish to give up smoking? **YES** **NO** (Please circle)

Have you ever been given advice on how to give up smoking, e.g. advice leaflets or counselling? **YES** **NO**

b) Have you stopped smoking? **YES** **NO** ______ (Enter date stopped)

How many cigarettes did you smoke in a day? ....

How many units of alcohol do you estimate you consume in one week? ______ Units (Please write number)

1 unit of alcohol = 1 measure of spirits (whisky, gin, vodka, brandy) or 1 small glass of wine or ½ pint of beer or lager

Have you ever been advised to stop drinking or to reduce the amount of alcohol you drink? **YES** **NO**

Do you exercise regularly? **YES** **NO** (Please Circle)

If **YES** what do you do? How Often?

FOR WOMEN ONLY

Date and result of last smear ---------- Number of Pregnancies ----------

Do you use any of the following methods of contraception? (Please tick box and give information if known)

Contraceptive Pill ☐ IUCD ☐ Implant ☐ Depo Injection ☐

Further Information:

Do you have a family history (Mother, Father, Brother, Sister) of:

	(Please circle)		Elaborate (Mother, Father, etc, giving age when diagnosed)
Cancer	**YES**	**NO**	
Heart Disease	**YES**	**NO**	
Stroke	**YES**	**NO**	
Diabetes	**YES**	**NO**	
Asthma	**YES**	**NO**	
Epilepsy	**YES**	**NO**	

If your parents are still alive, are they in good health?

Mother	**YES**	**NO**	
Father	**YES**	**NO**	

If your parents are dead, at what age did they die and from what?

	AGE	**CAUSE OF DEATH** (if known)
Mother		
Father		

YOUR OWN MEDICAL DETAILS:

Do you personally suffer from:	(Please circle)		Elaborate
Allergies	**YES**	**NO**	
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	**YES**	**NO**	
Diabetes	**YES**	**NO**	
Heart Disease/Angina	**YES**	**NO**	
Raised Blood Pressure	**YES**	**NO**	
Epilepsy	**YES**	**NO**	
Stroke	**YES**	**NO**	
Under/Overactive Thyroid	**YES**	**NO**	
Raised Cholesterol	**YES**	**NO**	
Cancer	**YES**	**NO**	
Mental Health problems, e.g. depression	**YES**	**NO**	
Any other medical conditions	**YES**	**NO**	

Previous medical history: Operations, hospital admissions, major illnesses. (Please give dates)

List any medication you are currently taking:
(Prescribed and/or over the counter)

Are you taking any supplements (eg iron, vitamins, calcium etc)

Did you have a Flu Vaccination in the preceding 1 September to 31 March? **YES** **NO** Please enter date

Do you have a Carer? YES/NO Name Relationship

Are you a Carer? YES/NO If **Yes** a) Relationship of person you look after

b) Do you require Carer's Needs Assessment **YES/NO**