Monifieth Medical Practice

New Patient Questionnaire

Welcome to Monifieth Medical Practice – a few extra details will help us understand your background and health needs better. Thank you for filling in this form.

Your Contact Details

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other	Surname
Date of birth / /	First names
Occupation	Previous Surname
Marital Status	
Address	
	Postcode
Home Tel No	Mobile Tel No.
Work Tel No	Email
Do you consent to the practice contacting you by text? Yes ☐ No ☐	

Next of Kin Details

Name	Relationship to you
Address	
Home Tel No,	Mobile tel No

Preferred Communication Options

What is your first language?	
Ethnic group *Please select one*	White (British, Scottish, Continental Europe, Irish)
	Black (Caribbean, African)
	Asian (India, Pakistan, China, Indonesia, other)
	Mixed / Other (please state)
Do you need a translator?	Yes ☐ No ☐
If so, which language?	

Disability

Are you registered disabled?	Yes ☐ No ☐
Please give details	

Carer Status

Do you have a carer ?	Yes ☐	No ☐	Please give details
Are you a carer?	Yes ☐	No ☐	Please give details
Do you have a future care plan?	Yes ☐	No ☐	Please give details

Medication

Please list any medication that you take including prescribed or over the counter drugs, including all pills, inhalers, creams or other forms of treatment			
Medication	Dose	How often taken?	For what condition?

Do you have any drug allergies (please state)	
Are there any of these medicines you would like to discuss with your new GP or Practice Pharmacist?	

Medical History

Your medical records will come through to us soon, but any information you can give us about serious illnesses, operations, accidents, disabilities and for women any pregnancy related problems and the approximate year they took place would be very helpful	

Mental health

Monifieth Medical Practice recognises the importance of good mental health and wellbeing so if you wish, please tell us here if you have ever suffered from a condition like Anxiety, Depression, Bipolar Disorder, Schizophrenia, OCD or any other mental health issues of which you would like us to be especially aware	

Women's Heath

Have you ever had a cervical smear?	Yes ☐ No ☐
Please state the last date (if known)	

Smoking or Vaping

Do you smoke or vape?	Smoke ☐ Vape ☐ Non-smoker ☐ If yes, how much do you smoke?
If 'No', have you ever smoked?	Yes ☐ No ☐ When did you quit?
Would you like advice on giving up smoking?	Yes ☐ No ☐

Alcohol

If 1 drink or unit = 1/2 pint of beer or 1 glass of wine or 1 single spirits
How many units do you drink in a week?
Please answer the following
MEN: How often do you have EIGHT or more drinks on one occasion? **WOMEN:** How often do you have SIX or more drinks on one occasion? Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐
How often during the last year have you been unable to remember what happened the night before because you had been drinking? Never ☐ Less than Monthly ☐ Monthly☐ Weekly☐ Daily ☐
How often during the last year have you failed to do what was normally expected of you because of drinking? Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily ☐
In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? No ☐ Yes, on one occasion ☐ Yes, more than once ☐

Other substance use

Have you ever used recreational or illicit drugs?	Yes ☐ No ☐
If so, would you like help for this?	Yes ☐ No ☐

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer if known.)	
Illness	Relationship to You
Illness	Relationship to You
Illness	Relationship to You

Additional Support Needs

If you wish, please tick any special needs that apply to you and if you can, give details	
Hearing problems?	Yes ☐ No ☐
Vision problems?	Yes ☐ No ☐
Speech problems?	Yes ☐ No ☐
Mobility problems?	Yes ☐ No ☐
Learning Disability?	Yes ☐ No ☐
Dementia diagnosis?	Yes ☐ No ☐
Aspergers's or Autism diagnosis?	Yes ☐ No ☐
Any other additional needs?	Yes ☐ No ☐
Please Specify	

Anything Else?

Is there anything else you'd especially like to tell us about? Please use this box to do so, or add any other comment.

Please Sign Off

Signed	Date

Thank You