WELCOME TO
KIRRIEMUIR MEDICAL PRACTICE

Before coming to the surgery for your appointment we would be grateful if you would fill in the accompanying questionnaire. By doing so, you allow us to collect information that is important to all aspects of your care. If you are unsure about any of the questions, please ask when you come to the surgery. On your first visit you will be given an appointment with the Practice Nurse. We would be grateful if you would bring a sample of urine, in the bottle provided. In addition the nurse will check your height, weight, blood pressure and any medication you currently take.

DATE QUESTIONNAIRE COMPLETED.....

Name .....
Date of Birth .....
Address .....
.....
.....
Post Code .....
Tel. No .....
Maiden Surname .....
Previous Surname.....
Occupation.....

Next of Kin .....
Tel.....

Are You? Married ☐
Single ☐
Divorced ☐
Widowed ☐
Other ☐

Are you a Carer? YES/NO
If so, would you like us to pass your information to Angus Carers? YES/NO

Have you had any serious illness or operations?

Year	**Problem**

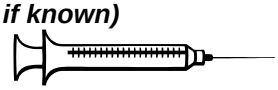
Are you taking any medicines at the moment?
If yes, Please bring your medication with you and please ask for an appointment with a GP before your medication runs out

Please list name, strength and dosage

Are you allergic to any drugs?

KIRRIEMUIR MEDICAL PRACTICE

Which of the following immunisations have you had in the last 10 years?
(Add date, if known)



☐ Polio
☐ Tetanus
☐ Rubella
☐ Hepatitis A
☐ Hepatitis B

WOMEN ONLY

Have you had a smear test?

If yes, when ……

where ……

Result …….

Are you on the pill, contraceptive injection or do you have a coil?

……..

No. of Pregnancies…….

Do your parents, brothers or sisters suffer from any of the following?

☐ Asthma
☐ Blood Diseases
☐ Bowel Cancer
☐ Breast Cancer
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Diabetes
☐ Duodenal Ulcer
☐ Eczema
☐ Epilepsy
☐ Glaucoma
☐ Gout
☐ Heart Disease
☐ High Blood Pressure
☐ Raised Cholesterol
☐ Overactive Thyroid
☐ Underactive Thyroid
☐ Manic Depression
☐ Migraine
☐ Obesity
☐ Psoriasis
☐ Rheumatoid Arthritis
☐ Schizophrenia
☐ Stroke
☐ Tuberculosis
☐ OTHER

CHILDHOOD ILLNESSES
(Have you/the patient had any of the following?)
Please tick

Mumps	☐	Whooping Cough	☐
Measles	☐	Rheumatic Fever	☐
Chickenpox	☐	Scarlet Fever	☐
Diphtheria	☐		
Asthma	☐		
Childhood Eczema	☐		
German Measles	☐		

UNDER 5'S IMMUNISATIONS
(Only complete for a child aged under 5)
Please tick if had

!st vaccine ☐ 2nd vaccine ☐ 3rd vaccine

MMR ☐ Men C ☐

Is there anything else you think we should know about you?

FOR OFFICIAL USE – to be completed by Practice Nurse

BP Reading ……
Weight …… Height ……..
Smoker ☐ …….. per day
Ex-Smoker ☐ Stopped ……. years/month
Never smoked ☐
Alcohol Consumption ……..
Urine……
Exercise: Heavy ☐ Moderate ☐ Light ☐
Physically Impossible ☐ Avoids exercise ☐

Ethnic Origin

We would be grateful if you would take the time to complete this form. Information on ethnicity is important because of the need to take into account culture, religion and language in providing appropriate individual care. By gathering this information we can monitor our performance with regard to race equality, and effect necessary improvements.

Can you please indicate your ethnic group by ticking the appropriate box below. If you would prefer not to complete this form then please tick here ❑

What is your ethnic group? *Choose ONE section, then tick the appropriate box to indicate your ethnic group.*

White
- ❑ Scottish
- ❑ British
- ❑ Irish
- ❑ Other white British ethnic group
- ❑ Any other White background (please write in) ……

Mixed
- ❑ White and Black Caribbean
- ❑ White and Black African
- ❑ White and Asian
- ❑ Any other mixed background (please write in) ……

Asian, Asian Scottish or Asian British
- ❑ Indian
- ❑ Pakistani
- ❑ Bangladeshi
- ❑ Any other Asian background (please write in) ……

Black, Black Scottish or Black British
- ❑ Caribbean
- ❑ African
- ❑ Any other Black background (please write in) ……

Chinese or other ethnic group
- ❑ Chinese
- ❑ Any other (please write in) ……

ARE YOU ALLERGIC TO ANY DRUGS? YES □ NO □

DRUG NAME(S): .....

REACTIONS: .....

.....

OTHER ALLERGIES: .....

SIGNED: .....