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| **OFFICIAL USE ONLY** | | |
| Input By: | Date: | Checked By: |

**Keppoch Medical Practice - New Patient Questionnaire**

**Please answer the following questions using CAPITAL LETTERS**

|  |  |  |  |  |
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| Surname |  |  | First Name |  |
| Marital Status (single/live with partner/married/divorced/widowed) |  |  | Date of Birth |  |

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| --- | --- | --- | --- | --- | --- | --- |
| Next of Kin |  | Relationship to patient | |  | | |
| Contact Tel No. for Next of Kin |  | Do you have a carer? | | Y/N | Are you an unpaid carer? | Y/N |
| Are you an asylum seeker? | | Y/N | Or a refugee? | | Y/N | |

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| --- | --- | --- | --- |
| Do you need an interpreter? If yes, what language do you speak? |  | | |
| Do you require sign language support? | Y/N | Do you have any other communication difficulties? | Y/N |

**Patients less than 16 years old. (To be completed by parent, guardian or support worker).**

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| --- | --- |
| Please list names and relationships to child of any other adults sharing the home. |  |
| Child’s nursery or school: |  |
| Support in place from other services, e.g. Social Work. If relevant, please name Support Worker. |  |

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| **ETHNICITY** | | √ |  |  | √ |  | √ |
| **White** | Scottish |  | **Asian** | Pakistani |  | **Black** |  |
|  | English |  |  | Pakistani Scottish/British |  | African |  |
|  | Welsh |  |  | Indian |  | African Scottish/British |  |
|  | N Irish |  |  | Indian Scottish/British |  | Black |  |
|  | Irish |  |  | Chinese |  | Black Scottish/British |  |
|  | Polish |  |  | Chinese Scottish/British |  |  |  |
|  | Other |  |  | Asian Other |  | **Arab** |  |
| **Mixed Ethnic Origin** | |  | **Other Origin not listed – please state:** | | | |  |

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| **Do you have any of these health conditions:** | | |  | **Do you have any Family members with these conditions?** | |
| Asthma |  | Heart Disease |  | Heart disease age under 60 |  |
| Cancer |  | High Blood Pressure |  | Stroke/mini stroke if age under 60 |  |
| COPD |  | Stroke/Mini stroke |  | Diabetes |  |
| Diabetes |  | Thyroid disease |  | Cancer |  |
| Epilepsy |  | Other – please detail overleaf | | Other – please detail overleaf |  |
| **General Health** |  | | | | |
| Height: | | Weight: | | Blood pressure (if known): | |
| Smoker: Current/ex-smoker/never | | Alcohol (approx units/week): | | | |

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| *I agree to the practice using any mobile number and e-mail provided by me to remind me of appointments by text and to send other important messages when necessary.* | | | |
| *Signature* |  | Admin Use Only | Date coded: |