Levenside Medical Practice

New Patient Medical

Forename	Surname	DOB
Address	Tel	Mobile
	Email	
	Allergies	Occupation
Post code	Number of Children	Marital Status

Next of Kin	Forename	Surname
Address	Tel	Mobile
	Postcode	Relationship to you

HAVE YOU PREVIOUSLY BEEN REGISTERED WITH THIS PRACTICE Y/N

History	Patient		Family		Details
	Yes	No	Yes	No	
Asthma					
Diabetes					
Epilepsy					
Hypertension					
MI					
Angina					
Stroke					
Cancer					
Hyperlipidaemia					
Vasc Disease					
Thyroid Disease					
Other					

Medication

Personal Medical History

Operations or disabilities

Smoking

Never smoked					
Ex cigarette smoker		Cigarettes per day	Cigarette smoker		Cigarettes per day
Ex Pipe smoker		oz per week	Pipe smoker		oz per week
Ex rolled tobacco		oz per week	Cigars		Cigars per day
Ex cigar smoker		Cigars per day	Roll-ups		oz per week

Date Stopped ……..

Alcohol consumption

Units per week

Date Stopped ……..

Exercise

Exercise Impossible	
None	
Light Exercise	
Heavy Exercise	
Other	

Do you have any allergies to foods of medicines Yes/No if yes please give details
……
……

Have you ever had your BLOOD PRESSURE TESTED? Yes/No
If so when?..... Has it ever been high/low Yes/No

Measurements

Height ……	Waist ……...	Tetanus date ……..
Weight ……	BP ……	Urinalysis……

Carers

Are you a carer, do you need/have anyone who looks after your daily needs as a carer Yes/No
Do you care for anyone else?
If 'Yes' ask the receptionist for Carers support

FEMALE PATIENTS ONLY

Do you use the Pill/Sheath/Coil/Cap/Nothing? ……..
If you take the contraceptive pill which one?.....
How long have you taken it for? ……..
Are you fitted with the coil? Yes/No When was it fitted? …….
Have you ever had a cervical smear test? How many time? ……..
Have you ever had a Miscarriage/Termination? Yes/No. How many …….
Have you ever had a hysterectomy? Yes/No When……..
Are you immune to Rubella (German Measles)? Yes/No …….

ETHNIC ORIGIN

White

Scottish	☐
English	☐
Welsh	☐
Northern Irish	☐
Irish	☐
Gypsy/Traveller	☐
Polish	☐

Other Ethnic Group

Arab	☐
Other	☐

Asian, Asian Scottish or Asian British

Pakistani, Pakistani Scottish or Pakistani British	☐
Indian, Indian Scottish or Indian British	☐
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	☐
Chinese, Chinese Scottish or Chinese British	☐
Other	☐

African, Caribbean or Black

African, African Scottish or African British	☐
Caribbean, Caribean Scottish or Cribbean British	☐
Black, Black Scottish or Black British	☐
Other	☐

Do you require the services of an interpreter Yes/I No

Any other white group …….. Any mixed or ethnic group……..

Signed…… Date……..