ANSTRUTHER PATIENT QUESTIONNAIRE

This set of questions has been designed to help your new General Practitioner get to know you and your medical problems. All questions will be handled confidentially by your doctor but if you are concerned about them please leave them blank and discuss it with your doctor. It would be appreciated if you could bring this form with you when you attend the nurse for your screening examination.

NAME………………………………………DATE OF BIRTH…………………...

ADDRESS…………………………………………………………………………

HOME AND MOBILE NUMBERS…………………………………......................

E-MAIL ADDRESS…………………………………………………

MARITAL STATUS…………………………..OCCUPATION……………………

Childhood Illnesses – ring those illnesses you have had and give approximate age

MUMPS	MEASLES	CHICKENPOX
DIPTHERIA	GERMAN MEASLES	SCARLET FEVER
RHEUMATIC FEVER	CHILDHOOD ECZEMA	WHOOPING COUGH
ASTHMA		

Please list all **serious illnesses, accidents, hospital admissions or operations** with dates and details of hospital.

Do you suffer from any **current illness?**

Present Medicines – Please list any medicines or tablets you are taking at present and the illness for which you are taking them:

Are you allergic or sensitive to any medicines, food, animals etc?

FAMILY HISTORY

Do you, or any of your family or close relatives, have any of the following illnesses or conditions:-

	YES/NO	Please Give Details
Diabetes	…………	…………………………………….
High Blood Pressure	…………	…………………………….............
Heart Attack	…………	…………………………………….
Stroke	…………	…………………………………….
Epilepsy or Fits	…………	…………………………………….
Asthma	…………	…………………………………….
Skin Disease	....	…………………………………….
Nervous Disorders	…………	…………………………………….
Allergies	…………	…………………………………….
Congenital Disease	…………	…………………………………….
Cancer	…………	…………………………………….
Kidney Disease	…………	…………………………………….
Twins	…………	……………………………………..
Other Diseases	…………	……………………………………..

Are your parents alive and in good health?

Mother…………………………………. Father……………………………………

If either has died could you please say how old they were when they died and what was the known cause of death.

Please list your **brothers and sisters** with their ages and give details of any serious illnesses they have suffered.

Is there any other information you think may be helpful? Please provide a next of kin contact.

WOMEN ONLY

Periods:-

Are your periods regular?..
How many days in the cycle?..
Is the bleeding heavy?..
How much pain do you get with your periods:-

Do you use contraceptives:- The Pill implant
Coil Diaphragm
Sheath sterilized

If you use the pill:-

How long have you been taking it?..

Do you get any side effects?..

What was the date of your last smear?...

Did you have the cervical cancer vaccine at school?

At what age did your periods finish?...(if relevant)

CHILDREN

Please list all the children that you have had:-

Name	Date of Birth	Difficulties with pregnancy or birth (& birth weight if known)

Have you had any miscarriages – Please give details

Any other relevant information:-

Immunisations

Please tick if you have been immunised against the following illnesses and if possible give the dates of last vaccinations.

Diphtheria…………… Date………..Smallpox…………………. Date……….......

Measles…………..... Date……….. Tetanus…………………… Date……….......

Polio……………….. Date……….. Influenza…………………. Date……….......

German measles…… Date……….. Typhoid………………….. Date……….......

Tuberculosis……….. Date……….. Whooping Cough………… Date……….......

Measles/Mumps/Rubella………Date…………. Meningitis........... Date......................

Pneumococcal ……………. Date…………… Rotavirus........... Date......................

Have you had any travel vaccines? Please provide name and details if possible.

Smoking

Do you smoke now?......... I
f yes how many daily ? Cigarettes……... Cigars……. Pipe……

How old were you when you started?.....................

Have you tried to give up?…….. Have you cut down recently?...............

What is the maximum you have smoked per day?...............

Are you interested in smoking cessation help?

If you have now stopped smoking:-

When did you stop smoking?........................ What was the maximum smoked?……...

Do you use e cigarettes? ....

Alcohol

How many units of alcohol do you consume a week?………………..
(1 unit = 1 glass of wine or ½ pint of beer)

Hobbies

Please list your hobbies, recreational and sporting activities:-

ETHNIC ORIGIN
This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care. Please ask a member of staff if you need more information.
We would be grateful if you could complete one for each family member within/joining the practice.

Name ……………………………………………….. DOB _ _ / _ _ / _ _

Do you need an interpreter or sign language support? ☐Yes ☐No

If you do need an interpreter what language do you speak?
……………………….

What is your ethnic group?
Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background

A White
- ☐ Scottish
- ☐ English
- ☐ Welsh
- ☐ Northern Irish
- ☐ British
- ☐ Irish
- ☐ Gypsy/Traveller
- ☐ Polish
- ☐ Any other white ethnic group, please write in
  …………………………………..

B Mixed or multiple ethnic groups
- ☐ Any mixed or multiple ethnic groups

C 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, please write in………………………………………………

D African, Caribbean or Black
- ☐ African, African Scottish or African British
- ☐ Caribbean, Caribbean Scottish or Caribbean British
- ☐ Black, Black Scottish or Black British
- ☐ Other, please write in ………………………………………………

E Other ethnic group
- ☐ Arab
- ☐ Other, please write in ……………………………………………..

If you do not wish to give this information, please tick here ☐