BALLANTRAE MEDICAL PRACTICE - NEW PATIENT INFORMATION

Please take a few minutes to complete the following details, which will be looked at by the Practice Nurse prior to your new patient medical.

**Personal Details**

|  |  |
| --- | --- |
| Name: | Address: |
| Date of Birth: |
| Home tel:Mobile: |

**Next of Kin Details**

|  |  |
| --- | --- |
| Name:  | Address: |
| Home tel:Mobile: |
| Relationship: |

**Ethnicity**

Choose ONE section from A to E then tick the appropriate box to indicate your cultural background.

|  |
| --- |
| **A White:** |
| Scottish □ | Other British □ | Irish □ |
| Other White background □ Please specify: |
| **B Mixed:** |
| Any mixed background □ Please specify: |
| **C Asian, Asian Scottish or Asian British:** |
| Indian □ | Pakistani □ | Bangladeshi □ | Chinese □ |
| Any other Asian background □ Please specify: |
| **D Black, Black Scottish or Black British:** |
| Caribbean □ | African □ |
| Any other Black background □ Please specify: |
| **E Other Ethnic background:** |
| Please specify: |

**Interpreter Services**

|  |
| --- |
| Do you need an interpreter? If yes, please specify: |
| No □ |  |
| Yes □ |
| For sign language please indicate: BSL □ Makaton □ |

**Carers**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you a carer? | No □ | Yes □ | If yes please state relationship: |
| Do you have a carer? | No □ | Yes □  | If yes please state relationship: |

**Exercise**

|  |
| --- |
| How many times a week do you do enough exercise to get breathless? |
| 0 times per week □ | Twice a week □ |
| Once a week □ | 3 times a week □ |

*Please continue overleaf*

**Alcohol Consumption**

|  |  |
| --- | --- |
| How many units of alcohol do you drink per week?  |  \_\_\_\_\_ units |

1 small glass of wine or half a pint of cider = 1.5 units of alcohol

Half pint normal strength lager/beer = 1 unit of alcohol

Small pub measure of spirits (25ml) = 1 unit of alcohol

(Please note, units are approximate and will depend on strength of alcohol in the drink)

**Smoking status**

|  |  |  |
| --- | --- | --- |
| Never smoked □ | Ex-smoker □ | Cigarette smoker □Number cigarettes/day \_\_\_\_ |
| Pipe smoker □Ounces tobacco/day \_\_\_\_ | Cigar smoker □Number cigars/day \_\_\_\_ |
| How long smoked \_\_\_\_ years |

**Past Medical History**

|  |
| --- |
| Do you have or have you had any of the following illnesses? |
| Diabetes □ | Asthma □ |
| Coronary heart disease □ | Overactive thyroid □ |
| High blood pressure □ | Under active thyroid □ |
| Stroke □ | Epilepsy □ |
| Other □ Please specify: |
| Please list any regular medication taken:Do you take Warfarin? Yes NoIf yes, please give date of last INR: Date due next INR: |
| Do you have any allergies? If yes, please specify: |
| No □ |  |
| Yes □ |

**Family History**

|  |
| --- |
| Do you have a family history of any of the following diseases? |
| Heart disease □ | Other □ Please specify: |
| Stroke □ □ |
| Asthma □ □ |
| Diabetes □ |

**Occupation**

|  |  |  |
| --- | --- | --- |
| Employed □ | Retired □ | Unemployed □ |
| Other □ Please specify: |

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