NEW PATIENT MEDICAL QUESTIONNAIRE

Mr/Mrs/Miss/Ms Name : ______________________ **D.O.B :** __________

Address : ______________________ **Tel. No. :** ______________________

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Past/Present Medical History :

Heart Disease	☐	Hypertension	☐
Diabetes	☐	Stroke	☐
Asthma	☐	Other	☐

Please specify ______________________

Family History :
Is there any of the following in your family...

		Which family member?	Before the age of 65?
Heart Disease	Y/N	______________	Y/N
Diabetes	Y/N	______________	Y/N
Hypertension	Y/N	______________	Y/N
Stroke	Y/N	______________	Y/N

Present Medication : ______________________

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Drug Reactions or Allergies : ______________________

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Next of Kin : ______________________ **Tel :** ______________

Smoking History :

Never smoked tobacco ☐
Ex. smoker ☐ Approx. year stopped : __________
Current Smoker ☐

Do you need an interpreter or sign language support? Yes No
If you do need an interpreter what language do you speak?
Please state …………………………………………………….
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