**New Patient Medical**

As your medical notes from your previous Doctor take some time to get to us we ask all new patients to complete this confidential questionnaire and arrange a general check-up with our Health Care Support Worker. These measures will give us a useful baseline and help us to readily identify any problems. Please complete this questionnaire and return it to Reception.

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | DOB |  |
| Address |  | Mobile |  |
|  |  |  |  |
| Post Code |  |  |  |
| **Emergency Contact** |  | Relationship |  |
| Contact Details |  |  |  |

**HAVE YOU PREVIOUSLY BEEN REGISTERED WITH THIS PRACTICE Y/N**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **History** | Yes | No |  | **Operations or disabilities** (List below) |
| Asthma |  |  |  |  |
| COPD |  |  |  |  |
| Diabetes |  |  |  |  |
| Epilepsy |  |  |  |  |
| Hypertension |  |  |  |  |
| MI |  |  |  | **Medication** |
| Angina |  |  |  |  |
| Coronary Disease |  |  |  |  |
| Stroke |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Cancer |  |  |  |  |
| Hyperlipidaemia |  |  |  |  |
| Vasc Disease |  |  |  |  |
| Thyroid Disease |  |  |  | **Allergies** |
| Mental Health |  |  |  |  |
| Other |  |  |  |  |

**MJOG Consent:**

We use a text reminder service to remind you of your upcoming appointments and occasionally Health Campaigns, for example, during Flu season (for those patients eligible).

Following the introduction of GDPR, we require your consent to send you messages this way.

I CONSENT to:

Receiving text message appointment reminders and Health Campaign Information

I DO NOT consent to:

Receiving text message appointment reminders and Health Campaign Information

We will confirm with you once your registration with the practice has been completed.  Until the registration is completed we will not be able to issue prescriptions or book appointments for you. **If you are on repeat medication from your previous GP you must produce evidence i.e. the re-order form.**

**Smoking Alcohol Consumption**

|  |  |
| --- | --- |
| Never Smoked |  |
| Current smoker |  |
| Ex smoker |  |

|  |  |
| --- | --- |
|  |  |
| Units per week |  |
|  |  |

Have you ever had your BLOOD PRESSURE TESTED **Yes/No**

If so, when ………………………… Has it ever been high/low **Yes/No**

**CARERS**

Are you a carer? Do you need/have anyone who looks after your daily needs as a carer **Yes/No**

**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 miscarriage/termination. If so when?

Have you ever had a hysterectomy? **Yes/No**  When

Are you immune to Rubella (German Measles)? **Yes/No**

**ETHNIC ORIGIN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **White** |  |  | **Asian, Asian Scottish or Asian British** |  |
| Scottish |  |  | Pakistani, Pakistani Scottish or Pakistani British |  |
| English |  |  | Indian, Indian Scottish or Indian British |  |
| Welsh |  |  | Bangladeshi, Bangladeshi Scottish or Bangladeshi British |  |
| Northern Irish |  |  | Chinese, Chinese Scottish or Chinese British |  |
| Irish |  |  | Other |  |
| Gypsy/Traveller |  |  |   |  |
| Polish |  |  | **African, Caribbean or Black** |  |
|  |  |  | African, African Scottish or African British |  |
| **Other Ethnic Group** |  | Caribbean, Caribbean Scottish or Caribbean British |  |
| Arab |  |  | Black, Black Scottish or Black British |  |
| Other |  |  | Other |  |

|  |  |
| --- | --- |
| Any other white group  |  |
| Any mixed or ethnic group  |  |

**INTERPRETER**

Do you need an interpreter? If so, which language:

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed**  |  | **Date** |  |

**Prescribing Protocol for New Patients:**

It is the policy of the Braehead Medical Practice to review medication and offer dose reduction where appropriate to ensure safe and effective prescribing, particularly for those drugs that can be harmful or addictive.

These include:

* Diazepam
* Lorazepam
* Temazepam
* Gabapentin
* Pregabalin
* Tramadol
* Morphine
* Other Opioids

By registering with us, you are agreeing to work with us to make sure your medication is safe and if deemed appropriate for you, you will participate in a dose reduction program.

Signed­­­­­­­­­­­­­: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_