NEW PATIENT QUESTIONNAIRE

Drumnadrochit Medical Practice

We would be grateful if you could complete this questionnaire.
It will help us to help you until your records arrive from your previous doctor.

Today's date	
Surname	**First name(s)**
Date of birth	
Address	
Postcode	
Telephone / Mobile no.	
Name of previous GP	
Address of previous GP	
Past medical history	
Current medical problems	
Current medications	
Allergies / hypersensitivities	

Family history
Is there a history of the following conditions in your immediate family?

Condition	**Relationship**	**Age of onset (approximate)**
Asthma		
Diabetes mellitus		
High blood pressure		
Heart attack		
Stroke		
Others …		

For adults

Do you smoke?	Cigarettes / pipe? How much?
Do you drink alcohol?	Units per week
Weight	Height
Date of last tetanus vaccination	

For women

Number of pregnancies	Number of children
Date of last cervical smear	
Contraception	