NEW PATIENT FORM - ADULT AND CHILDREN OVER 6 YEARS

GREAT WESTERN MEDICAL PRACTICE
Seafield Road, Aberdeen, AB15 7YT,
Tel. 0345 337 0540

PERSONAL DETAILS

Full Name ______________________

Sex:
Female ☐
Male ☐

Date of Birth ______________________

Address ______________________

Preferred Pronoun ______________________

(Postcode) ______________________

Place of Birth ______________________

Email Address ______________________

Telephone numbers

Home ______________________

Office ______________________

Mobile ______________________

If you DO NOT wish to be added to the text reminder service, please tick here. ☐

Nationality ______________________

Marital Status ______________________

Occupation ______________________

No of children/dependants, with names and ages

____

Next of kin (name, address, tel.)

____

Which ethnic group do you belong to? – You are not obliged to complete this section

Please tick as appropriate

☐ White ☐ Chinese ☐ Bangladeshi ☐ Black-African

☐ Pakistani ☐ Indian ☐ Black Caribbean

☐ I do not wish to give this information

Other – please state ______________________

Signature ______________________

Date ______________________

YOUR OWN MEDICAL DETAILS

Height ____________________ Weight ____________________

Do you personally suffer from:

	Yes	No	Details
Allergies	Yes ☐	No ☐	____________
Asthma/Chronic Obstructive Pulmonary Disease (COPD)	Yes ☐	No ☐	____________
Diabetes	Yes ☐	No ☐	____________
Heart Disease/Angina	Yes ☐	No ☐	____________
Raised Blood Pressure	Yes ☐	No ☐	____________
Epilepsy	Yes ☐	No ☐	____________
Stroke	Yes ☐	No ☐	____________
Under/Overactive Thyroid	Yes ☐	No ☐	____________
Raised Cholesterol	Yes ☐	No ☐	____________
Cancer	Yes ☐	No ☐	____________
Mental Health problems, e.g. depression	Yes ☐	No ☐	____________
Any other medical conditions	Yes ☐	No ☐	____________

Previous medical history: Operations, hospital, admissions, major illnesses. (Please give dates)

____

____

____

Record of vaccinations (please bring copy if you have one)

____

____

____

Do you have a Carer? Yes ☐ No ☐

Name ____________________

Relationship ____________________

.

Are you a Carer?

a) Relationship of person you look after ____________________

Do you require Carer's Needs Assessment? Yes ☐ No ☐

Have you **ever** smoked cigarettes or tobacco?

If you have answered '**YES**' to the above question, please answer **either** a) or b) below:
If you have answered '**NO**' please to the next section.

a) How many cigarettes do you smoke in a day? ……………. (Please write in number)

Do you wish to give up smoking? Yes ☐ No ☐

Have you ever been given advice on how to give up smoking,
e.g. advice leaflets or counselling? Yes ☐ No ☐

b) Have you stopped smoking? Yes ☐ No ☐

Enter dated Stopped ____________________

How many cigarettes did you smoke in a day? ____________________

How many units of alcohol do you estimate you consume in one week? ____________ Units

1 unit of alcohol =	1 measure of spirits (whisky, gin, vodka, brandy)
	or 1 small glass of wine
	or ½ pint of beer or lager
If you do not drink any alcohol, please write in '0'.	

Have you ever been advised to stop drinking or to reduce
The amount of alcohol you drink? Yes ☐ No ☐

Do you have a family history (Mother, Father, Brother, Sister) of: (please circle)

			Details (Mother, Father, etc giving age when diagnosed)
Cancer	Yes ☐	No ☐	
Heart Disease	Yes ☐	No ☐	
Stroke	Yes ☐	No ☐	
Diabetes	Yes ☐	No ☐	
Asthma	Yes ☐	No ☐	
Epilepsy	Yes ☐	No ☐	

If your parents are still alive, are they in good health?

Mother	Yes ☐	No ☐
Father	Yes ☐	No ☐

If your parents have passed away, at what age did they die and from what?

	AGE	**CAUSE OF DEATH** (if known)
Mother		
Father		

List any medication you are currently taking.

Name of Medication	Strength	Dose per day

Preferred Pharmacy - All Prescriptions will be sent to your nominated Pharmacy

Anderson and Spence	☐	Dickies Summerhill	☐
Albyn Pharmacy	☐	Ferryhill Pharmacy	☐
Boots Mannofield	☐	Garthdee Pharmacy	☐
Boots Mastrick	☐	Holburn Pharmacy	☐
Boots Garthdee	☐	Kingswells	☐
Boots Bon Accord	☐	Lewis Road Pharmacy	☐
Boots Union Square	☐	Michies Rosemount	☐
Bairds Pharmacy	☐	Michies Union Street	☐
Clear - Alford Place	☐	Peterculter Pharmacy	☐
Clear - Holburn Street	☐	Robert Whitelaw - Waverly Place	☐
Cults Pharmacy	☐	Rowlands Cults	☐
Davidsons	☐	Rosemount Pharmacy	☐

Did you have a Flu Vaccination in the preceding 1 September to 31 March?

Yes ☐ No ☐ Please enter date ______________

Have you had a Pneumoccocal Vaccination given?

Yes ☐ No ☐ Please enter date ______________

Private Health Insurance?

Yes ☐ No ☐ Company? ______________

Screening Questions.

Please answer if you had cervical and breast screening done.

Date and result of last smear ______________

Were the Results - Normal ☐ Abnormal ☐

To be repeated? Date ______________

Do you know when you last breast check was? Date ______________

If using contraception please tick your current

Pill ☐ Implant ☐ Coil ☐ Other ______________