NEW PATIENT FORM - ADULT AND CHILDREN OVER 6 YEARS

OneMedical Group	GREAT WESTERN MEDICAL PRACTICE Seafield Road, Aberdeen, AB15 7YT, Tel. 0345 337 0540
PERSONAL DETAILS	
Full Name	Sex: Female
Date of Birth	Male
Address	Preferred Pronoun
(Postcode)	Place of Birth
Email Address	
Telephone numbers Home	
Office	
Office	
Mobile	
If you DO NOT wish to be added to the text reminder service,	
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 Please tick as appropriate	o complete this section
White Chinese	Bangladeshi Black-African
Pakistani Indian	Black Caribbean
I do not wish to give this information	Other – please sta <u>te</u>
Signature	

Date

YOUR OWN MEDICAL DETAILS

Height	Weight		
Do you personally suffer from:			
Allergies	Yes	Details 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, adm	nissions, major illne	esses. (Please give dates)	
Record of vaccinations (please bring copy if you have	ve 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.

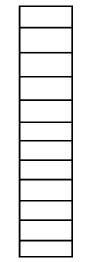
a)	How many cigarettes do	you smoke in a day?		(Please writ	e in number)	
	Do you wish to give up sn	noking?	Yes		No	
	Have you ever been giver e.g. advice leaflets or cou	_	ıp smoking, Yes		No	
b)	Have you stopped smokir	ıg?	Yes Enter dated		No	
	How many cigarettes did	you smoke in a day?		u Stopped		
How man	y units of alcohol do you estir	nate you consume in one	e week?			Units
1 unit of a If you do i	or	spirits (whisky, gin, vodka 1 small glass of wine ½ pint of beer or lager write in '0'.	a, brandy)			
	I ever been advised to stop unt of alcohol you drink?	drinking or to reduce	Yes		No	
Do you ha	ive a family history (Mother, F	Father, Brother, Sister) of	f:	(please o	circle) ils (Mother, Fathe	er etc aiving
					en diagnosed)	si, ete giving
	Cancer	Yes	No			
	Heart Disease	Yes	No			
	Stroke	Yes	No			
	Diabetes	Yes	No			
	Asthma	Yes	No			
	Epilepsy	Yes	No			
If your pa	rents are still alive, are they ir	n good health?				
	Mother	Yes	No			
	Father	Yes	No			
If your pa	rents have passed away, at w	hat age did they die and	from what?			
		AGE		CAUSE OF D	DEATH (if known)
	Mother					
	Father					
					Daga2	

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 Albyn Pharmacy Boots Mannofield Boots Mastrick Boots Garthdee Boots Bon Accord Boots Union Square Bairds Pharmacy Clear - Alford Place Clear - Holburn Street Cults Pharmacy Davidsons



Dickies Summerhill Ferryhill Pharmacy Garthdee Pharmacy Holburn Pharmacy Kingswells Lewis Road Pharmacy Michies Rosemount Michies Union Street Peterculter Pharmacy Robert Whitelaw - Waverly Place Rowlands Cults Rosemount Pharmacy

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

Did you have a rid vaccination in the prec		
Yes No	o Please enter	date
Have you had a Pneumoccocal Vaccinatio Yes No		date
Private Health Insurance? Yes No	c Company?	
Screening Questions. Please	answer if you had cervical and b	reast 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	Data Data	
If using contraception please tick your cur		