

Kessington Medical Centre

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NEW PATIENT HEALTH QUESTIONNAIRE			
Please complete this and bring with you to the Health Promotion Clinic along with a fresh urine sample			
Name (BLOCK LETTERS)		Date of Birth	
Address		Email address: BLOCK LETTERS	
Home tel no		Mobile number	
Marital status		Occupation	
Next of kin to be contacted in emergency			
Name (BLOCK LETTERS)		Home tel no	
Address		Mobile number	

Please use back page for any continuation of answers

1. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:-			
	YES	NO	Details (including dates)
a) Heart problems			
b) Breathing problems			

c) Diabetes			
e) High Blood Pressure			
f)Stroke			
g)Blood problems			
h)Gut problems			
i)Cancer			
j)Mental health issues including stress/depression etc			
k)Operations			
l)Other			

2. IS THERE A FAMILY HISTORY OF ANY OF THE ABOVE A-L? YES NO

If YES PLEASE LIMIT THIS TO IMMEDIATE FAMILY AND STATE APPROXIMATELY AT WHAT AGE? (BEFORE OF AFTER > 60 YEARS)

Details

3 ARE YOU ON ANY PRESCRIBED MEDICATION? **YES** **NO**

Please state name of drug, dose and reason for taking it.

Please attach prescription re-order list if available.

If you are on medication please make an appointment with doctor as well as the nurse.

Drug Name	Dose	Frequency	Reason

4. DO YOU HAVE ANY ALLERGIES? Please list below **YES** **NO**

e.g. Penicillin, Hay Fever

DRUG ALLERGIES - Please detail name of drug, type of reaction and dates

NON-DRUG ALLERGIES– Please detail substance, type of reaction and dates

5. SMOKING STATUS. PLEASE TICK APPROPRIATE BOX.

- I have never smoked
- I am an ex smoker Date stopped _____
 Number smoked _____
- I am a current smoker per day _____
- Are you interested in stopping smoking? YES NO

6. IN THE AVERAGE WEEK, HOW MANY UNITS OF ALCOHOL DO YOU DRINK? _____ Units

(1 pint of beer is 2 units, a measure of spirit 1 unit, a small glass of wine 1 unit).

7. EXERCISE (IN THE PAST WEEK)

- In the past week on how many days have you
- (a) been physically active for a total of 30 minutes or more? _____ DAYS
- (b) Have you been active for at least 2.5 hours over the course of the past week? YES
 NO
- (c) Are you interested in being more physically active? YES
 NO

DATE _____

SCREENING INFORMATION

Men answer Section 8 AND 12-13 only. Women answer ALL sections.

8 .Immunisation

Have you been immunised against:

- a. Tetanus in the last 10 years YES APPROX DATE _____ NO
- Was this given by a hospital or a GP? Hospital GP
- b. Polio in the last 10 years YES APPROX DATE _____ NO
- c. If a child, is your immunisation programme up to date YES NO

Women Only

9. Cervical Screening (25 years- 70 years)

If you are a woman over 25, have you had a cervical smear in the last 3 years? YES
If yes, please give details below NO

Date	Result	Where Performed (Hospital or GP)
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10. Breast Screening

Have you had a Mammogram (Breast X-ray)? YES NO

If so, please give details below.

11. Do you use any form of contraceptive? If so, please specify.

(We appreciate that this is a sensitive area and will be treated with confidence. It will help your medical management, however, if your doctor is aware of this information.)

12. Have you had a Bowel Screening Test recently? If so, please specify.

ADDITIONAL INFORMATION:

13. Do you have any problems not referred to above which you would like your doctor to know about?

Baseline Measurements (Please leave blank – to be completed at the Clinic)

Height Ft _____ Ins ____ Metres _____

Weight St _____ lbs ____ Kgs _____

BMI _____

Blood Pressure _____ / _____ Date _____

Urine Analysis _____

PLEASE USE THIS SHEET IF NECESSARY FOR FURTHER INFORMATION

Lined writing area consisting of 20 horizontal lines.