**Stenhouse Medical Centre Under 16’s New Patient Questionnaire**

**Patient Details**

|  |  |  |
| --- | --- | --- |
| First Name(s)/Middle Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Sex: Male □ Female □ |
| Current Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other addresses – Please provide all other addresses you have lived in the last 3 years.  ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date from:\_\_\_/\_\_\_/\_\_\_ Date to: \_\_\_/\_\_\_/\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date from:\_\_\_/\_\_\_/\_\_\_ Date to: \_\_\_/\_\_\_/\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date from:\_\_\_/\_\_\_/\_\_\_ Date to: \_\_\_/\_\_\_/\_\_\_  Continue on separate sheet if necessary | | |
| Telephone Numbers:  Mobile – \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home – \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Main Spoken Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you consent for Text Messaging Service? Yes □ No □  Preferred Method of Communication: □Letter SMS □ | |

**Ethnic Group**

|  |  |
| --- | --- |
| Black | □Caribbean |
|  | □African |
|  | □Other (please specify) |
| Mixed | □White & Black |
|  | □Pakistani |
|  | □Chinese |
|  | □Other (please specify) |

|  |  |
| --- | --- |
| White | □British |
|  | □Irish |
|  | □Other (please specify) |
| Asian | □Indian |
|  | □Pakistani |
|  | □Chinese |
|  | □Other (please specify) |

**Next of Kin or Foster/Carer Details**

|  |  |
| --- | --- |
| Full Name: | Relationship to You: |
| Address | Contact Number and other details |
| Full Name: | Relationship to You: |
| Address | Contact Number and other details |

**Medical History Allergies**

|  |  |
| --- | --- |
| Do you suffer with any of the following?  (Please tick) | □Asthma |
| □Cancer |
| □Diabetes |
| □Epilepsy |
| □Visually Impaired |
| □Hearing Impaired |
| □Learning Disabilities |
| □Other – please detail |

|  |  |
| --- | --- |
| Please give details of any/if any allergies you have: |  |

**Medication**

|  |  |
| --- | --- |
| Do you have a repeat prescription from your previous GP Surgery? **\*If so, please attach a copy of your repeat slip\*** | □Yes □No |

|  |  |
| --- | --- |
| Would you like to sign up for Electronic Prescribing? | □Yes □No  If yes, which Pharmacy would you like to be signed up with?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For Office Use:**

Form taken by –

**Sign:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Print:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_

**For Management Use**

|  |
| --- |
| **Needs an appointment with:**  **□Respiratory Nurse**  **Date: □Doctor**  **Name: □Diabetes Nurse**  **□No Action**  **□Recalls Added**  **□HV Informed** |