Thurso & Halkirk Medical Practice

HEALTH QUESTIONNAIRE

These questions have been designed to assist your new General Practitioner in gaining an understanding of your medical history. The information provided will be handled confidentially but, should you have any concerns about completing any of the medical details, please leave them blank.

APPLICANT'S DETAILS – TO BE COMPLETED IN FULL AND IN BLOCK CAPITALS

Title (Circle):	Mr/Mrs/Ms/Miss/Master/Dr/Rev/Other
Surname:	
Forenames:	
Date of Birth:	
Place of Birth:	
Nationality:	
Ethnic Origin:	*Please complete attached form*
First Language:	
Occupation:	
Tel No (Home):	
Tel No (Work):	
Tel No (Mobile):	
Consent (see separate info/forms re consent for other (incl Online) services	

Do you consent to us contacting you by text message if we decide to communicate in this manner at some point in the future?	YES / NO
Are you happy for us to leave a phone message for you to make contact with the surgery? No details will be given apart from a request to make contact.	YES / NO
Do you consent to us contacting you by email if we decide to communicate in this manner at some point in the future?	YES / NO
Email Address:	
Have you been known by a previous name at any time? If so, please give details below	
Previous Surname(s):	
Previous Forename(s):	

Current Address (incl Postcode):	
Last Address (incl Postcode):	
Last Doctor's Name and Address (incl Postcode):	
Have you been registered here before?:	YES/NO
Please give approx date:	
Have you been treated here before?:	YES/NO
Please give approx date:	
Do you have any relatives or cohabiters who are, or have been registered with this Practice?	YES/NO
If yes, please give name(s):	
Name & Relationship of Next of Kin:	
NOK Contact Tel No:	
Are you a Carer for someone who is ill, frail, disabled or mentally ill?	YES / NO
If you answered yes, please complete an Identification of Carer form available from Reception	
Have you ever had any involvement with a Social Worker (currently or previously)?	YES / NO
If you answered yes, please give name and contact telephone number:	

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MEDICAL DETAILS – TO BE COMPLETED BY ALL PATIENTS (IN FULL)

Please give details of any major operations, health problems or serious accidents; plus details of any current illnesses. You can attach a continuation sheet if you wish.

Date (approx)	Description of Ailment	Problems still to be encountered (if applicable)

Medication – Please list any pills, tablets, or other medicines that you are currently taking (incl over the counter medication). If this medication has been prescribed on repeat prescription by your previous GP please ensure that you have a sufficient supply to last until you are registered with this Practice. You must attach a copy of the repeat prescription request slip issued by your previous GP. If you would like your prescription to be sent to the local Pharmacy (for Princes Street Surgery patients only), then please let us know by nominating the Pharmacy below:

Williamsons / Sutherlands / Well Pharmacy

Name & Strength of Medication	Dose	Times per day	Prescribed for (name of ailment)
Are you allergic or sensitive to any medicines, food, animals, etc?			YES / NO
If yes, please give details:			

SMOKING

Have you ever smoked?	YES / NO	If yes, how many cigarettes smoked per day?	
Have you now stopped smoking?	YES / NO	If yes, please give approximate date?	

ALCOHOL

How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

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Current Height:		Current Weight:	
Date of Last Tetanus Vacc (if known):		Date of last BP Check (approx):	
Date of 1st Covid Vaccination Date of 2nd Covid Vaccination Date of 3rd Covid Vaccination Date of Covid Booster Vaccination		Type eg Pfizer, Astra Zeneca, etc Type eg Pfizer, Astra Zeneca, etc Type eg Pfizer, Astra Zeneca, etc Type eg Pfizer, Astra Zeneca, etc	

Please list any **illnesses** that "run in your family" eg Diabetes, Heart Disease (Attacks), Glaucoma, etc. This relates to your parents, brothers and sisters only.

Illness	**Family Member**	**Illness**	**Family Member**

MEDICAL DETAILS TO BE COMPLETED FOR CHILDREN ONLY

Please give dates of all CHILDHOOD IMMUNISATIONS and/or indicate if the child has not been immunised

Age	Immunisation								
	Diphtheria Tetanus Pertussis Polio, Hib Hep B	Diphtheria Tetanus Pertussis Polio	Pneumococcal (PCV)	Meningitis B (Men B) (from 1.9.15)	Rotavirus	Hib Meningitis C	MMR	Diphtheria Tetanus Polio	Men C ACWY
8 weeks									
12 weeks									
16 weeks									
12-13 mths									
From 3.5yrs									
14-18 yrs									

	1st Dose	2nd Dose
Girls aged 12-13 yrs - HPV		

MEDICAL DETAILS TO BE COMPLETED BY ADULT FEMALES ONLY

Date of last cervical smear?		Date of last breast examination?	
How many pregnancies have you had?		How many children do you have?	
Have you had a hysterectomy?	YES / NO	Have you been sterilised?	YES / NO
Do you take the contraceptive pill?	YES / NO	Do you have a coil or implant fitted?	YES / NO

Applicants Signature:		**Date:**	

Princes Street Surgery (01847)893154
Halkirk Surgery (01847)831203