Ratho Medical Practice

New Patient Questionnaire – Adult

Name:	Date of Birth:

Address:	
Home Telephone No:	Mobile:

Marital Status :

Have you ever been registered at Ratho Medical Practice before? If so, under what name were you registered & when?	Yes / No

Ethnicity – Please tick one box only.

White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups	Decline to provide Ethnic Group
☐	☐	☐	☐	☐	☐

MEDICAL BACKGROUND

ALLERGIES - **Do you have any allergies? If YES please list below:**

Drug Related Allergies:	
Non-Drug Related Allergies:	

Are you taking any medication? **Yes/No** **(please circle)**

(If you have a repeat prescription slip from your previous Practice please attach)

Smoking status - Do you smoke? (Please tick the appropriate boxes)

Yes ☐ **No** ☐ **Ex- smoker** ☐

Do YOU have a history of any of the following Medical Conditions? (Tick box)

Diabetes	Asthma	Epilepsy	Heart Disease	Mental Health Depression	Stroke	COPD
☐	☐	☐	☐	☐	☐	☐

Is there a family history of serious illness?
If so what?

FEMALE APPLICANTS (Aged 18 and over) ONLY

CERVICAL CYTOLOGY CONFIRMATION

Please fill in sections below:

I hereby confirm that I had a Cervical Smear performed:

Which Country? ____

When ? ____

The result was reported to me as **normal/abnormal** (please circle)

I was advised to have my next smear ___________________ (please enter approx date)

Any other appropriate information you feel would be useful:

Thank you for your assistance in completing this Questionnaire.
Please hand it back with your Registration Form. If you are taking any regular prescribed medication you will require a GP consultation.