**Ratho Medical Practice**

 **New Patient Questionnaire – Adult**

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| **Name:** | **Date of Birth:** |

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| **Address:****Home Telephone No: Mobile:** |

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| **Marital Status :**  |

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

**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 Stroke COPD

 Depression

**Is there a family history of serious illness?**

**If so what?**

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| **FEMALE APPLICANTS (Aged 18 and over) ONLY**CERVICAL CYTOLOGY CONFIRMATIONPlease 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:

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| --- |
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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.