

SA1 Medical Centre
NEW PATIENT QUESTIONNAIRE (Student)

Name: _____ Date of Birth: _____

Address: _____ Postcode: _____

Contact Nos _____ Email Address: _____

What is your first language? _____ Ethnicity: _____

Do you need an interpreter? _____ Yes / No _____ Gender: _____

NEXT OF KIN

Name: _____ Relation: _____

Address: _____ Postcode: _____

Contact Nos _____ Email Address: _____

SMOKING STATUS

Non Smoker: _____ Yes / No _____

Number per day: 1 - 9 10-19 20-39 40+

Ex-smoker Date ceased: _____ Please circle or tick above how many you used to smoke

Would you like help to stop smoking: _____ Yes / No _____

ALCOHOL STATUS (1 UNIT = ½ pint beer, lager, cider, 1 single spirit, 1 small glass of wine)

Teetotaller _____ Yes / No _____

Light drinker: Less than 1 unit daily/1-6 units weekly

Moderate drinker: 1-2 units daily/7-14 units weekly

Heavy drinker: 3-6 units daily/21-42 units weekly

Very heavy drinker: 7-9 units daily/49-63 units weekly

Stopped drinking: _____ Date ceased: _____ Please tick above how much you used to drink

EXERCISE STATUS

No Exercise Avoid even trivial exercise Unable to exercise due to health

Light Exercise Moderate exercise Heavy exercise

Competitive Athlete

Weight and Height if known: _____ Weight: _____ Height: _____

ALLERGIES/SENSORY PROBLEMS:

Do you have any allergies or sensory problems: _____ Yes / No _____

If Yes, please give details

Current Illnesses:

Current Medication:

It is the patient's responsibility to provide evidence of any current medication from their previous practice.
It is our Practice Policy for **ALL** new patients to be reviewed.

FAMILY HISTORY: Does your father, mother, brother or sister suffer from any of the following:

Please tick the relevant condition and indicate which relative and age at diagnosis if known.

If the relative died of the condition please give age at death if known. **NB It is your FAMILY history that is required.**

Heart Disease age 60 or under

Heart disease age over 60

Diabetes

Hypertension/High Blood pressure

Stroke/TA

Hyperlipidaemia/High Cholesterol

Cancer

Type: _____

CARERS:

Do you need/have anyone who looks after you or your daily needs as Carer?

Yes / No

If Yes, would you like them to deal with your health affairs here?

Yes / No

(A member of Reception staff can help with these arrangements)

Do you care for anyone else?

Yes / No

(If Yes, please ask the Reception staff about Carers' support)

In respect of information from the Practice regarding appointments/results etc.:

Consent to receive SMS texting:

Yes / No

Consent to receive Emails:

Yes / No

Meningitis C Vaccination (ACWY)

It is advisable for all first year students to have the Meningitis C vaccination due to all students coming from different parts of the country and abroad. It is more likely that students living and working in close proximity to each other might be more susceptible to contracting viruses, germs and/or bacteria.

Have you had the Meningitis C Vaccination (ACWY):

Yes / No

Signature: _____

Name: _____

Date: _____