High Mill Medical Practice
Drs Macleod, Lindsay, Thompson & Zonfrillo
Carluke Community Health Centre
40 Chapel Street
Carluke ML8 4BA
Tel No 01555 771012 Fax No 01555 777464

NEW PATIENT INFORMATION

SURNAME: ……….......................... **FORENAME** ………………………….

FULL ADDRESS: ……………………………………………………………………………..

TEL NO. HOME: ………………………….. **WORK** ....

E'MAIL ADDRESS: ………………………………………………………………..

MOBILE NO: …………………………………………
(We will contact you where possible on your landline)

MARITAL STATUS: ……………………… **DATE OF BIRTH:** ……………………..

COUNTRY OF BIRTH: …………………….. **SEX MALE / FEMALE**

OCCUPATION: ……………………………………………………….

NEXT OF KIN:

RELATIONSHIP TO PATIENT: ……………………………………

CONTACT TEL NO & ADDRESS ……………………………………………………

DO YOU SMOKE Y / N
IF YES HOW MAY CIGARETTES DO YOU SMOKE PER DAY …………………..
IF NO HAVE YOU EVER SMOKED ………… WHEN DID YOU STOP ……………..

DO YOU DRINK Y / N
IF YES HOW MUCH DO YOU DRINK PER WEEK OF WINE ………………
BEER ………………
SPIRITS ………………

DO YOU TAKE REGULAR EXERCISE: Y / N
WHAT TYPE OF EXERCISE DO YOU UNDERTAKE…………………………………

DO YOU HAVE ANY ALLERGIES Y / N
IF YES PLEASE STATE WHAT THESE ARE:

PLEASE LIST ANY PREVIOUS ILLNESSES OR OPERATIONS

………………………………………………………………. **YEAR OF ONSET** ……………

……………………………………………………………… **YEAR OF ONSET** …………...

.... **YEAR OF ONSET** ……………

PLEASE LIST CURRENT MEDICATION/S - Include strength of medication & amount taken daily:

PLEASE LIST ANY HOSPITAL REVIEWS & REFERRALS WHICH YOU ARE CURRENTLY UNDERTAKING:

PLEASE GIVE DETAILS OF FAMILY HISTORY

INDICATE WHICH RELATIVE HAS SUFFERED ANY OF THE FOLLOWING AND IF POSSIBLE THEIR AGE AT TIME:

HEART ATTACK …………………… **DIABETES** …………………………………

CANCER ……………………………… **SITE OF TUMOUR (if known)**……………

ASTHMA ……………………………… **TUBERCULOSIS** ………………………….

STROKE ………………………………. **BLOOD PRESSURE** ………………………

ANY OTHER SERIOUS ILLNESS ……………………………………………………………..

VACCINATIONS

PLEASE INDICATE WHICH YOU HAVE HAD AND WHEN (wherever possible):

CHILDHOOD VACCINATION PROGRAMME YEAR COMPLETED: ____________

RUBELLA …………………………… **BCG** ………………………………

HEP A ……………………………… **MENINGITIS** ………………………

HEP B ………………………………… **TETANUS** …………………………..

OTHER …………………………………………………………………………………….

FEMALE PATIENTS

HAVE YOU HAD CHILDREN Y / N

IF YES HOW MANY …………………….. THEIR AGE/S: ……………………….

HAVE YOU HAD A HYSTERECTOMY? Y / N

IF YES PLEASE STATE YEAR OF OPERATION …………………..

IF APPLICABLE WHICH FORM OF CONTRACEPTION DO YOU USE ……………….

WHEN DID YOU HAVE YOUR LAST CERVICAL SMEAR ? ……………………………

MEASUREMENT

HEIGHT (SELF MEASURE) …………………………………..

WEIGHT (SELF MEASURE) ………………………………….

CARERS

DO YOU HAVE A CARER Y / N
(Excluding employed or carers from a Voluntary Organisation)

DO YOU CARE FOR SOMEONE WHO IS FRAIL OR UNWELL? Y / N

IF YES, WOULD YOU LIKE TO GIVE A NAME …………………………………..

PLEASE REMEMBER TO BRING SOME IDENTIFICATION WITH YOU WHEN RETURNING YOUR FORMS TO THE RECEPTIONIST.
This can be :-

1. **Medical Card**
2. **Birth Certificate**
3. **Passport**
4. **Current Utility Bill with your Name & Address on it.**

SIGNATURE ………………………………………. DATE …………………………