SOUTH BEACH MEDICAL CENTRE – PATIENT QUESTIONNAIRE

PERSONAL DETAILS:

Name..... Date of Birth.....

Address..... Post Code.....

Telephone - Home..... Mobile.....Email.....

In the event of an emergency, who should we contact? Name..... Telephone.....

Next of Kin details - Name..... Relationship..... Telephone.....

CURRENT MEDICAL HISTORY: Tick any which apply

Heart Problems_____ Diabetes_____ Chest Problems_____

Stroke_____ High Blood Pressure_____ Depression/Mental illness _____

Kidney/bladder problems_____ Epilepsy_____ Surgical procedures_____

Are you hearing impaired_____ Registered Blind_____

FAMILY HISTORY –

Heart Attack: Yes/ No If yes, please select Father/Mother/Sibling at age_____

Stroke: Yes/No If yes, please select Father/Mother/Sibling at age_____

High Blood Pressure: Yes/No If yes, please select Father/Mother/Sibling at age_____

Any other family history_____

MEDICATION – Do you take regular medication? Please provide a copy of your re-order list if possible.
We will not issue prescriptions for sedatives, strong painkillers e.g. Tramadol, Codeine, Gabapentin/Pregabalin until we receive confirmation from your previous surgery. (Please list and continue on reverse if necessary)

_____

Prior to 1996 only
Have you ever had a blood transfusion Yes / No If so, have you been tested for Hepatitis C Yes / No

Allergies
Do you have any allergies _____

For Women only to complete
Have you ever had a smear test Yes/No If so, when was the last_____

Do you use contraceptive methods If so, please select oral contraceptive / coil/ implant

Do you hold a Shot Gun Licence or Firearms Certificate? Yes / No

Date of last approval _____ Date renewal due _____

Communication
If English is not your first language, do you need an interpreter Yes /No First language_____

Why did you leave your previous GP practice?

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