NEW PATIENT INFORMATION CARD

DATE: ……

SURNAME: ……

FIRST NAME(S): ……

FULL ADDRESS: ……

……

TEL NO (HOME): …… TEL NO (WORK): ……

E-MAIL ADDRESS: ……

MARITAL STATUS: …… DATE OF BIRTH: ……

COUNTRY OF ORIGIN: …… SEX: ……

OCCUPATION: ……

PHARMACY YOU WISH TO USE FOR PRESCRIPTIONS: ……

GENERAL HISTORY

Have you had any serious illnesses or operations, x-rays or similar tests and when?

……

……

Do you suffer from indigestion, e.g., heartburn? ……

What medicines are you taking? ……

……

Have you any allergies to medicines or anything else?

……

What is your smoking status?:

Never smoked: …… Ex-smoker: …… Current smoker: ……

If you are a smoker, there are Stop Smoking Support Sessions available in West Lothian. Please ask at Reception for a leaflet.

The one in Armadale is held in the Community Centre on Wednesdays between 12 noon and 1.00 pm.

How much alcohol do you consume per week (quantity)?

Wine: …….. Beer: ……. Spirits: ……

FAMILY HISTORY

Which of your blood relatives have suffered from the following:

Heart Attack □ …….. Cancer □ ……..

Diabetes □ …….. High Blood Pressure □ ……

Asthma □ …….. Tuberculosis □ ……..

Stroke □ …….. Other Serious illness □ ……

VACCINATIONS

Which vaccinations have you had and when?

Diphtheria □…….. Polio □ ……..

German Measles □ …….. Tetanus □ ……..

Typhoid □ …….. Measles □ ……..

Cholera □ …….. BCG □ ……

Yellow Fever □ …… MMR □ ……..

Whooping Cough □ ……..

FOR FEMALE PATIENTS ONLY

Have you had any children? Yes/No Give ages: ……

Have you had a miscarriage? Yes/No Date: ……

Have you had a termination of pregnancy? Yes/No Date: ……..

Have you had a hysterectomy? Yes/No Date: ……..

What method of contraception are you using at present?

……..

When was your last smear test? ……

What was the result? ……..

When should you next have a smear test? ……

Please list below names, address and dates of birth of children that you care for (do not include children that you care for as part of your profession, if applicable):

NAME	ADDRESS	DATE OF BIRTH

DO NOT COMPLETE THIS SECTION

Date:

Urine		Glucose		Albumin	
BP		Weight		Height	

NEXT OF KIN FORM

PATIENT'S NAME: .....

PATIENT'S ADDRESS: .....

.....

PATIENT'S DATE OF BIRTH: .....

I confirm that the person named below is my Next of Kin/Emergency Contact and I authorise you to release this information to the emergency services and/or hospital if required.

Next of Kin/Emergency Contact (1)

NAME: .....

ADDRESS: .....

.....

TELEPHONE NUMBER: .....

RELATIONSHIP: .....

Next of Kin/Emergency Contact (2)

NAME: .....

ADDRESS: .....

.....

TELEPHONE NUMBER: .....

RELATIONSHIP: .....

* I consent to the sharing of Key Information from my medical records with Out-of-Hours, ambulance service, NHS 24 or A&E Department in the event of an emergency situation (* delete if consent not given)

Signed: ..... Date: .....

This information will not be shared with any party other than indicated and is completely secure.