



Welcome To Airthrey Park Medical Centre University of Stirling New Patient Medical Questionnaire

Until we receive your medical records from your previous GP practice, can you please take a few minutes to complete this questionnaire. This will enable us to update our records.

Personal Details

Surname: _____ First Name: _____

Date of Birth: _____ Telephone No: _____

University Address: _____

Postcode: _____ Email: _____

University Leaving Date: _____

Emergency Home Contact Details

Name: _____ Relationship: _____

Home Address: _____

_____ Telephone No: _____

Personal History

Do you have a history of, or are you currently receiving medication/treatment for: (please tick as appropriate).

Asthma Cancer Heart Disease Chronic Kidney Disease

Hypothyroid Disease COPD Epilepsy Diabetes

Stroke/TIA Respiratory Disease Hypertension

Please list any other health conditions: _____

Any previous surgical operation: Yes No Details: _____

Medications

Please list any medications you are currently taking: _____

Please list any medications you may be allergic to: _____

Vaccination History

Please tick and provide dates as appropriate:

Tetanus Date: _____ Polio Date: _____

Meningitis C Date: _____ BCG Date: _____

Mumps, Measles and Rubella (MMR) Date: _____

Smoking Status

Do you smoke? (please tick) Current Smoker Never Smoked Ex-Smoker

Carers and Being Cared For

Do you look after someone? Yes No

Does someone look after you? Yes No

Ethnic Origin (please tick as appropriate)

White

Scottish
British
Irish
Other Background

Asian or Asian British

Bangladeshi
Indian
Pakistani
Other Background

Mixed

White and Asian
White and Black African
White and Black Caribbean
Other Background

Black or Black British

African
Caribbean
Other Background

Other

Chinese
Other Background (please state) _____

Prefer not to say

For Women Only

Have you ever had a cervical smear? If yes, date of last smear: _____