

KILLEARN HEALTH CENTRE
NEW PATIENT MEDICAL HISTORY

NAME _____ DATE OF BIRTH _____

ADDRESS _____ MARITAL STATUS _____

_____ OCCUPATION _____

HOME TEL NO _____ MOBILE _____

E MAIL ADDRESS _____

EMERGENCY CONTACT NAME _____ TELEPHONE _____

ARE YOU A CARER? _____ IF SO FOR WHO? _____

DO YOU HAVE A CARER? _____ CONTACT DETAILS _____

Current health Problems

Previous illnesses and operations

Current Medication

Allergies

Family History

SMOKING

Do you smoke? _____ **ALCOHOL**
If yes, how many? _____
Did you ever smoke? _____

Do you drink alcohol? _____
Amount weekly? _____

EXERCISE

What type? _____
How often? _____

Female Patients

Number of Pregnancies _____

Date of Last Cervical Smear _____

Children
Details and Dates of Immunisations

Is there any particular reason why you joined Killearn Health Centre: _____

What is your ethnic group?

Choose ONE section from A to E then tick ONE box which best describes your ethnic group or background

A White

- Scottish
- English
- Welsh
- Northern Irish
- British
- Irish
- Gypsy/Traveller
- Polish
- Any other white ethnic group, please write in

B Mixed or multiple ethnic groups

- Any mixed or multiple ethnic groups

C Asian, Asian Scottish or Asian British

- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British
- Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- Other, please write in

D African, Caribbean or Black

- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Other, please write in

E Other ethnic group

- Arab
- Other, please write in: _____