Pipeland Medical Practice
St Andrews Community Hospital
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Pipeland
MEDICAL PRACTICE

ADULT MEDICAL QUESTIONNAIRE AND CONTACT PREFERENCES

1. Contact information

Title _____ Name _____ Date of birth _____

Tel: *Home* _____ *Work* _____

Mob _____ Email address _____

2. Who is your next of kin?

Name: _____ Relationship to you: _____

Telephone: _____ Mobile no.: _____

3. Do you have any allergies to any substances/medications? Yes ☐ No ☐ If Yes, please state below:

Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____

4. Are you taking any regular prescribed medicines (incl. contraception and any medications prescribed by a hospital consultant) Yes ☐ No ☐ If yes, please provide a copy of your repeat prescription form from your previous surgery. If unavailable, please list your current medications and doses.

Name _____ Dose _____
Name _____ Dose _____
Name _____ Dose _____

5. Have you any current medical problems requiring ongoing treatment? Yes ☐ No ☐

a) _____ b) _____
c) _____ d) _____
e) _____ f) _____

6. Is there any other health issue you would like us to know about? Yes ☐ No ☐

_____
_____

7. Do you have any documents in place regarding your future care e.g. Anticipatory Care Plan, Living Will, Power of Attorney, DNACPR etc.? Yes ☐ No ☐ If yes, we will check these are held within your previous health record and may contact you to discuss if not otherwise available.

_____
_____

8. Smoking

Do you smoke? Yes ☐ No ☐ If yes, how many a day? _____
Are you an ex-smoker? Yes ☐ No ☐ If yes, when did you stop? _____

CONTACT INFORMATION AND CONSENT TO TEXT MESSAGING AND EMAILS

Please complete this form and return it to the Practice.

Name..... DOB.....

Home telephone number..... Mobile number.....

Email address.....

The Practice can contact me by text (please tick) YES ☐ NO ☐

The Practice can contact me by email (please tick) YES ☐ NO ☐

The telephone numbers and email address I have provided are those of a parent (please tick)
YES ☐ NO ☐

The telephone numbers and/or email address is shared with another person (please specify below)

I confirm I understand what is being asked of me and that if my parent's details are held on my record as contact information, they will receive text reminders of my appointments and may be contacted by the Practice regarding other matters.

If a mobile number or email address is shared with another person, I understand that person will have access to information sent by the Practice by text or email, for example appointment reminders.

Signed.....

The Practice will update your records in line with your wishes. You can contact us at any time if you wish to make any changes. If you are under **16** years of age we will check with you again in a year.