



ILKLEY MOOR AND GRASSINGTON
Primary Care Services

**IG Medical New Patient
Questionnaire**

Please complete in FULL using BLOCK CAPITALS

Title:		Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Transgender <input type="checkbox"/>					
Surname:		Town and Country of birth:					
Forename:		Date of birth:					
Mobile Tel No: Home Tel No: Email Address:		Ethnicity:					
First Language:	English Speaker:	Height:		Weight:			
Do you suffer from any of the following (answer YES or NO)							
Asthma		Stroke/Mini Stroke					
Diabetes – Type I <input type="checkbox"/> Diabetes – Type II <input type="checkbox"/>		Atrial Fibrillation					
Sickle Cell		Cancer					
Epilepsy		Obesity					
Depression		Raised Blood Pressure Needing Treatment					
Serious Mental Health Problems e.g. eating disorder If YES, please specify:		Heart Disease					
Under-Active Thyroid (hypothyroidism)		Polycystic Ovary Syndrome					
Are you currently taking any medication? If YES, please list <i>(Please attach a copy of any previous repeat medications. Please note you may be invited for a medication review with a GP or Pharmacist before your medication is issued.)</i>							
Pharmacy Choice, Please tick : Ilkley Moor Pharmacy <input type="checkbox"/> Boots Ilkley <input type="checkbox"/> Pharmacy plus Health Ilkley <input type="checkbox"/> Rowlands Addingham <input type="checkbox"/> Cohens Burley In Wharfedale <input type="checkbox"/> Boots Grassington <input type="checkbox"/>							
Are you allergic to any medications?			Do you have any other allergies? E.g. Hayfever, animals, dust				
Is there a history of any of the following conditions in your family before the age of 60?							
Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/>							
Do you smoke? Never <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Current Smoker <input type="checkbox"/> E- Cigarette <input type="checkbox"/> If Current Smoker : Would you like advice on stopping smoking? Yes <input type="checkbox"/> No <input type="checkbox"/>							
Alcohol:		Scoring system					
		0	1	2	3	4	Score
How often do you have a drink containing alcohol?		Never	Monthly Or less	2-4 Times Per Month	2-3 Times Per week	4+ Times Per week	
How many drinks containing alcohol do you drink in a typical day when you are drinking?		1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more drinks if female, or 8 or more if male, on a single occasion in the last year?		Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

