

**PATIENT QUESTIONNAIRE**  
**FORTROSE MEDICAL PRACTICE**

*We thank you for taking the time to complete this question sheet. Please fill in as much as you can, as this will help us to provide you with the best possible care.*

**PERSONAL DETAILS**

Last Name .....	Maiden Name.....
First Name .....	Marital Status ( <i>please circle</i> ) Single / Married / Divorced / Widowed
Address .....	Date of birth .....
.....	Occupation ( <i>present or previous</i> ) .....
Postcode .....	Employer.....
Telephone No. ....	
Mobile No.....	

**FAMILY HISTORY**

**Please tell us of any serious illnesses suffered by your close relatives.**

- Mother
- Father
- Brothers
- Sisters
- Children

**PERSONAL MEDICAL HISTORY**

Illness or operations

Current medical problems

Allergies

Immunisations (dates if known):    Tetanus                      Polio                      Other

*(For children under 5 – parents please bring along red book)*



## **LOOKING AFTER SOMEONE**

Do you look after or take responsibility for a parent, spouse/partner, child, relative, friend or neighbour who is unlikely to be able to manage at home without support? They may be frail due to sickness or old age, have a physical or learning disability, sensory impairment, mental health, drug or alcohol problems.

No  Not sure  Yes

Do you look after or keep an eye on:

1 person  2 people  More than 2 people

Is this person/are these people your:

Grandparent  Parent  Spouse/partner  Brother/Sister  Child

Relative  Friend  Neighbour  Other

In total, approximately how many hours per week do you look after, do chores for, or sort out problems for them?

1- 19 hours per week  20-49 hours per week  over 50 hours per week

Do you know about the range of services, information, advice and support available for carers (people who keep an eye on, look after or take responsibility for someone)?

No  Not sure  Yes

## **BEING LOOKED AFTER**

Does someone look after or keep an eye on you, because you are not able to manage at home without help?

No  Not sure  Yes

Is this person/are these people your:

Grandparent  Parent  Spouse/partner  Brother/Sister  Child

Relative  Friend  Neighbour  Other

## PATIENT ETHNIC ORIGIN FORM

*This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.*

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section below and then tick ONE box to indicate your background.

Name..... Date of Birth.....

### White

Scottish		9i21
British or Mixed British		9i0
Irish		9i1
Other White – please write below		9i2

### Mixed

White and Black Caribbean		9i3
White and Black African		9i4
White and Asian		9i5
Any other mixed background please write below		9i6

### Asian or Asian British

Indian or British Indian		9i7
Pakistani or British Pakistani		9i8
Bangladeshi or British Bangladeshi		9i9
Any other Asian background please write below		9iA

### Black or Black British

Caribbean		9iB
African		9iC
Any other black background please write below		9iD

### Chinese or other ethnic group

Chinese		9iE
Any other please write below		9iF
<b>Declined / Not stated</b>		9iG

Shaded areas for office use only