Barns
MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE

(16 years and under)

Please complete as fully as possible and hand in to the Receptionist at your earliest convenience.

CONTACT DETAILS

Name ..... Date of birth .....

Address .....Post Code .....

Please provide the following details. We will only use these contact details if you agree by ticking the box

Home telephone number ☐ (tick if you agree to contact by this method) .....

Mobile telephone number ☐ (tick if you agree to contact by this method) .....

Email address ☐ (tick if you agree to contact by this method).....

Please circle the ethnic group which applies to you:

White/Scottish White/Other Indian Pakistani Chinese
Bangladeshi Black (African) Black (Caribbean) Black (Other)
Other (please specify) .....

MEDICAL CONDITIONS AND TREATMENT

Please give a brief description of any:-

a) Medical Conditions.....

b) Operations .....

c) Present treatment .....

d) Are you aware of any adverse reactions to drugs, or do you suffer from any allergies?

Yes ☐ No ☐ If yes, please give details .....

40 DALBLAIR ROAD, AYR, AYRSHIRE, KA7 1UL
TEL: 01292 281439 FAX: 01292 288268
PRESCRIPTION LINE: 01292 272140
WWW.MEDICAYR.CO.UK

MEDICAL HISTORY (14 years and above)

Which of the following best describes you:

I have never smoked ☐ I am an ex smoker ☐ I currently smoke ☐

Date stopped …… How many do you smoke?

per day ……..

Would like advice on stopping? (Please ask the Receptionist for details)

☐

VACCINATION HISTORY

Please indicate childhood immunisations received, giving dates where possible:-

VACCINE	1st course	2nd course	3rd course	Booster	Reinforcing
Diphtheria, Tetanus, Pertussis, Polio, HIB, Meningitis C, Pneumococcus					
MMR(measles/mumps/rubella)					
BCG (tuberculosis)					
Rubella (German Measles)					
HPV (Human Papilloma Virus) Females only					

Have you had any of the following vaccinations in the last 10 years:-

Influenza ☐

Pneumococcus ☐

Travel vaccines ☐

NEXT OF KIN *(please provide details of whom to contact in the event of an emergency)*

Name ……..…… Relationship ……..……..

Contact telephone number ……

CARER DETAILS

Do you provide care for someone? Yes ☐ No ☐

We can offer advice and support, please ask for details at Reception

Signature of Parent/Guardian……..……Date ……

40 DALBLAIR ROAD, AYR, AYRSHIRE, KA7 1UL

TEL: 01292 281439 FAX: 01292 288268

PRESCRIPTION LINE: 01292 272140

WWW.MEDICAYR.CO.UK