**Grove Health Centre**

**129 Dundee Road, Broughty Ferry, Dundee DD5 1DU**

**Tel: 01382 778881 Fax: 01382 731884**

[**www.grovehc.co.uk**](http://www.grovehc.co.uk)

**NEW PATIENT QUESTIONNAIRE**

Please ensure the information below is completed fully when registering with the practice:

|  |
| --- |
| **TITLE - FULL NAME -**  **DATE OF BIRTH -**  **ADDRESS -**  **HOME NUMBER - MOBILE NUMBER -** |

|  |
| --- |
| **ARE YOU ARE CURRENT SMOKER? YES / NO**  **HAVE YOU PREVIOUSLY SMOKED? YES / NO**  **DO YOU DRINK ALCOHOL? YES / NO**  **HOW MANY UNITS OF ALCOHOL PER WEEK?** |

|  |
| --- |
| **DO YOU HAVE ANY ALLERGIES(PLEASE GIVE DETAILS)? YES / NO** |

|  |
| --- |
| **DO YOU SUFFER FROM ANY OF THE FOLLOWING?**  DIABETES - YES / NO (If YES – TYPE 1 OR TYPE 2)  ASTHMA - YES / NO  COPD - YES / NO  HIGH BLOOD PRESSURE - YES / NO  HISTORY OF STROKE - YES / NO  ANGINA - YES / NO  HISTORY OF HEART ATTACK - YES / NO  AF - YES / NO  HYPOTHYROIDISM - YES / NO |

|  |
| --- |
| **PATIENT SIGNATURE: DATE:** |