



Liberton medical group

Today's date

Title

First name

Surname

Address

Date of birth:

Postcode

Telephone no.

How do you wish to be addressed?

Name:

Any operations or serious illnesses?

Do you have or have you ever had:

| | | |
|------------------------------------|--------------------------|-----------------|
| Asthma | <input type="checkbox"/> | Date Diagnosed: |
| Diabetes | <input type="checkbox"/> | Date Diagnosed: |
| Chronic Bronchitis | <input type="checkbox"/> | Date Diagnosed: |
| A stroke or Transient attack (TIA) | <input type="checkbox"/> | Date Diagnosed: |
| Under active thyroid | <input type="checkbox"/> | Date Diagnosed: |
| Heart Attack or angina | <input type="checkbox"/> | Date Diagnosed: |
| Epilepsy | <input type="checkbox"/> | Date Diagnosed: |
| High blood pressure | <input type="checkbox"/> | Date Diagnosed: |

Has anyone in your near family had
Any of the following

Heart attack
Asthma

Stroke
High Blood pressure

Are you taking any medication?

Name

Dose

How often?

Do you have any allergies?

Occupation:

Do you smoke? Yes / ex smoker / never smoked How many do / did you smoke a day?:

Do you drink yes / never How many units of alcohol per week?:
(1 unit = 1 glass of wine, 1 pub shot of spirits or 1/2 pint beer)

Immunisations:

When was your last tetanus? Date: >10 yrs ago Don't know:
When was your last polio? Date: >10 yrs ago Don't know:
Have you ever had a pneumococcal vaccination? Date: Yes No

Ladies:

When was your last cervical smear? Date: >5 yrs ago Don't know:
Was it a normal result? Yes No
Have you ever had treatment for an abnormal smear? Yes No
Have you ever had mammography? (breast X-rays) Yes No
Current contraception used?
Number of pregnancies?:

To be completed by the Doctor / Practice Nurse

Height BMI
Weight
Blood Pressure /
Urinalysis
Action: Data in GPASS?
Referred to GP?