Blackfriars Medical Practice
St Andrews Community Hospital
Largo Road, St Andrews,
Fife, KY16 8AR

Tel 01334 477477
www.blackfriarsmedicalpractice.gp.scot

ADULT MEDICAL QUESTIONNAIRE AND CONTACT PREFERENCES

1. Contact information

Title _____ Name _____ Date of birth _____

Address _____ Tel home _____

Mob _____ Email address _____

2. Who is your next of kin?

Name: _____ Relationship to you: _____

Telephone: _____ Mobile no.: _____

3. Do you have any allergies to any substances/medications? Yes ☐ No ☐ If Yes, please state below:

Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____

4. Have any of your relatives had any of the following conditions? If so please detail who:

Name _____ Heart Disease _____
Epilepsy _____ Diabetes _____
Stroke _____ Hypertension _____

5. Have you any current medical problems requiring ongoing treatment? Yes ☐ No ☐

a) _____ b) _____
c) _____ d) _____
e) _____ f) _____

6. Alcohol intake

Do you drink alcohol? Yes ☐ No ☐ If yes, how many units per week? _____

7. Smoking

Do you smoke? Yes ☐ No ☐ If yes, how many a day? _____
Are you an ex-smoker? Yes ☐ No ☐ If yes, when did you stop? _____

8. Height and Weight

What is your current height? _____ CM
What is your current weight? _____ KG

CONTACT INFORMATION AND CONSENT TO TEXT MESSAGING AND EMAILS

Please complete this form and return it to the Practice.

Name..... DOB.....

Home telephone number..... Mobile number.....

Email address.....

The Practice can contact me by text (please tick) YES ☐ NO ☐

The Practice can contact me by email (please tick) YES ☐ NO ☐

The telephone numbers and email address I have provided are those of a parent (please tick)
YES ☐ NO ☐

The telephone numbers and/or email address is shared with another person (please specify below)

I confirm I understand what is being asked of me and that if my parent's details are held on my record as contact information, they will receive text reminders of my appointments and may be contacted by the Practice regarding other matters.

If a mobile number or email address is shared with another person, I understand that person will have access to information sent by the Practice by text or email, for example appointment reminders.

Signed.....

The Practice will update your records in line with your wishes. You can contact us at any time if you wish to make any changes. If you are under **16** years of age we will check with you again in a year.