

ANCRUM ONE

ANCRUM ONE
12-14 ANCRUM ROAD
DUNDEE
DD2 2HZ

TELEPHONE: 01382 669500
FAX: 01382 669522

Dear Patient

PLEASE RETURN TO RECEPTIONIST ONCE COMPLETED. THANK YOU

.....
QUESTIONNAIRE: Do not worry if you cannot complete this all.

FULL NAME DATE OF BIRTH

ADDRESS

.....

TELEPHONE NUMBER MOBILE NUMBER

OCCUPATION

MARITAL STATUS

.....

NEXT OF KIN

RELATIONSHIP TO YOU

NAME

ADDRESS

TELEPHONE NUMBERMOBILE NUMBER.....

.....

ANY ILLNESS OR OPERATIONS

(Please give dates)

.....

PRESENT DRUG TREATMENT

(Please give dose)

.....

PLEASE TURN OVER-→

ANY KNOWN ALLERGIES.....

.....

ETHNIC ORIGIN: (Please circle)

White	Black Caribbean	Black African	Black, other, non-mixed origin
Indian	Pakastani	Bangladeshi	Other ethnic non-mixed
Chinese			Other ethnic, mixed origin

.....

ARE YOU A CARER?

RELATIONSHIP TO YOU.....

NAME

ADDRESS

TELEPHONE NUMBERMOBILE NUMBER.....

.....

DO YOU HAVE A CARER?

RELATIONSHIP TO YOU.....

NAME

ADDRESS

TELEPHONE NUMBERMOBILE NUMBER.....

.....

ARE YOU PREGNANT YES () No () IF YES HOW MANY WEEKS ()

DO YOU SMOKE YES () NO () HOW MANY PER DAY ()

DO YOU WANT HELP TO STOP SMOKING YES () NO ()

NEVER SMOKED ()

EX SMOKER () HOW LONG HAVE YOU BEEN STOPPED ()

CIGAR SNOKER () HOW MANY PER DAY ()

PIPE SMOKER () HOW MUCH PER DAY ()

TOBACCO SMOKER () HOW MUCH PER DAY ()

WHAT IS YOUR PREFERRED PHARMACY
TO HAVE ANY PRESCRIPTIONS SENT TO -

PLEASE RETURN TO RECEPTIONIST ONCE COMPLETED. THANK YOU