The O’Connell Street Medical Practice

**Confidential Medical Questionnaire**

**Name:** ..................................................................................**Date of Birth** ..................................

**Address:** ............................................................................................................................................

 ............................................................................................................................................

 .................................................................................. **Postcode** .......................................

**Contact Tel No’s:**

**Landline Tel No :** .................................................................................

**Mobile Tel No : .**................................................................................

**E-mail Address : .**................................................................................

**Past Medical History – Please update below.**

**Medical Conditions**................................................................................................................................

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**Surgical Operations**...............................................................................................................................

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**Accidents** .................................................................................................................................

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**Children**

**Has your child completed a full course of infant immunisations including a pre-school booster? YES □ NO □**

**Medicines - Please list all your present medicines / pills**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication (Drug) Name** | **Dosage** | **Day / Quantity** | **Please Mark if Medication is Repeat (R) or Acute (A)** | **Please advise if Your Medication is Issued in the following format Compliance Aid (CA), Dispense Weekly (DW)****and / or** **(CMS) Chronic Medication Service** |
| **1.** |  |  |  |  |
| **2.** |  |  |  |  |
| **3.** |  |  |  |  |
| **4.** |  |  |  |  |
| **5.** |  |  |  |  |
| **6.** |  |  |  |  |
| **7.** |  |  |  |  |
| **8.** |  |  |  |  |
| **9.** |  |  |  |  |
| **10.** |  |  |  |  |
| **11.** |  |  |  |  |
| **12.** |  |  |  |  |

**Drug Allergies – Please list below ................................................................................................................................................................**

**................................................................................................................................................................**

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**Please advise which Pharmacy you would like Signed Prescriptions to go to (Tick Box) below.**

|  |  |
| --- | --- |
| **Boots** |  |
| **Border Pharmacy** |  |
| **Crosby** |  |
| **Lindsey & Gilmour** |  |
| **Hawick Health Centre** |  |
| **None – Pick up Signed Prescriptions at Surgery Reception** |  |

**Signature: ............................................................................. Date: ................................**