PLEASE HAND THIS BACK TO RECEPTION WHEN COMPLETE

To the Patient:
To register with the Practice please complete questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Prior to registering you must bring details of your medication (e.g. printout from previous practice)

Title: _____ Surname: _____ First Name: _____

Address: _____ Date of Birth: _ _ / _ _ / _ _ _ _

_____ Home Tel No: _ _ _ _ _ _ _ _ _ _ _ _

_____ Mobile/Work: _ _ _ _ _ _ _ _ _ _ _ _

Post Code: _____ Marital Status: _____

Ethnic Origin: _____ Gender: Male/Female/Other: _____

If you are from abroad, what date did you come to UK? _ _ / _ _ / _ _ _ _

E-mail address: _____ Occupation: _____

Main Spoken Language: _____

Do you consent to receiving text messages and/or email? Yes [ ] No [ ]

Do you need an Interpreter? Yes [ ] No [ ] If so, what language? _____

Previous address details (in last 5 years): _____

_____

Are you a carer? Yes [ ] No [ ] Who do you care for? _____

Do you have a carer? Yes [ ] No [ ] Who cares for you? _____

Contact telephone number for Carer: _ _ _ _ _ _ _ _ _ _ _

Children

Name of Health Visitor & or School Nurse: _____

Name of person(s) with parental responsibility: _____

Mother & father's names, d.o.b. & addresses, if different to the child's:

_____

Next Of Kin Details

Surname: _____ First name: _____

Address _____ Post code: _____

_____

Home Tel No: _ _ _ _ _ _ _ _ _ _ _ _ Mobile/Work: _ _ _ _ _ _ _ _ _ _ _ _

GENERAL HISTORY

ALLERGIES

Are you allergic to any medicines/substances/food? If so, to what?

_____

_____

MEDICATION

Please attach your repeat prescription order slip and list any regular over the counter or herbal medication you take. Medication requests take 2 working days to process, however this may take longer for your first order. DO NOT WAIT UNTIL YOU HAVE RUN OUT TO RE-ORDER:

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH PROMOTION

Smoking status

Do you smoke? Yes [ ] No [ ]
- If no, have you ever smoked? Yes [ ] No [ ] If Yes, when did you stop? _____
- If Yes, how many: Cigarettes per day: _____ Cigars per day: _____ Ounces of tobacco per day: _____

How old were you when you started smoking? _____
If you smoke, we strongly recommend that you stop.
Ask at reception for details of the stop smoking services.

Exercise

Do you take regular exercise? Yes [ ] No [ ]

If yes, what sort of exercise? _____

How many times per week? _____

Alcohol

How often do you have 8 **(for men)**/ 6 **(for women)** drinks of alcohol in one day? (Please Circle)
Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you not been able to remember what happened when drinking the night before? (Please Circle)
Never Less than monthly Monthly Weekly Daily or almost daily

How often during the last year have you failed to do what was normally expected of you because of your drinking? (Please Circle)
Never Less than monthly Monthly Weekly Daily or almost daily

Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down? (Please Circle)
No Yes, but not in the last year Yes during the last year

Have you now or in the past had problems with substance misuse? Yes/No (Please Circle)

FAMILY HISTORY

Please give details of any of your blood relatives (and their age), who have had any of the following:

Heart disease/attack/angina: _____ Diabetes: _____

Asthma: _____ Cancer: _____ Stroke: _____

High blood pressure: _____ Other serious illness: _____

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:
_____
_____
Please give details of any treatment for any chronic medical conditions:
_____
_____

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound scan:

_____

_____

VACCINATIONS

Please give dates of which vaccinations you have had (if known):-

Diphtheria: _____ Polio: _____ Tetanus: _____

Typhoid: _____ Measles: _____ HPV: _____

Cholera: _____ BCG: _____ Flu: _____

Yellow fever: _____ MMR: _____

Whooping cough:_____ German Measles/Rubella: _____

For children: a copy of the child's vaccination record would be helpful (eg from their Red Book)

FEMALE PATIENTS ONLY

When was your last smear test (if known) Year _ _ _ _ Result _____

Please give details of any complications in any pregnancy:

_____

THANK YOU FOR YOUR ASSISTANCE