Since it will be some time before we will have your medical records, we would be grateful if you could provide us with some information which will assist us in the meantime. You may wish to request a medical summary (along with medications list) from your previous GP to pass on to us.

If you are under the care of the hospital, you will also need to inform them of your new address and GP.

# **GENERAL INFORMATION TODAYS DATE:**

Name: Date of Birth: Age:

Male/Female Place of Birth: Ethnicity:

Address: .................................................................

Locality: .................................................................

City: .................................................................

Postcode: ....................................... Single/Married/Divorced/Widowed/

Living with Partner/Separated

Telephone Numbers: *(Please indicate your preferred contact number)*

Home:

Work:

Mobile:

*NB: We are able to contact you by text with appointment reminders. Please advise us if you would prefer NOT to be contacted this way.*

**PREVIOUS DETAILS;**

Previous address: ............................................ Previous Doctor:

Surgery Name:

............................................. Surgery Address:

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

Postcode: ..............................................

Occupation ………………………………… University/college student? ……………

First time in UK? Preferred spoken language .......................................................

Are you a carer? YES/NO

# Are you an H M Forces veteran? YES/NO

**NEXT OF KIN DETAILS OF YOUR CARER**

Name: Name:

Address: Address:

Tel. No.: Tel. No.:

Relationship to you: Relationship to you:

# **MEDICAL BACKGROUND**

Are you currently taking any medication?

Drug: Dosage:

## **ALLERGIES**

Do you have any allergies. If YES please list below

Drug Related allergies …………………………………………………...................................

Non Drug Related allergies ……………………………………………..................................

Weight ……………………… Height …………………………

## **MEDICAL HISTORY**

Please *circle* below any of the conditions that apply to you and *give dates* when occurred

Condition Date

High blood pressure - Last reading ……………….

Heart attack or Angina

Stroke

Cancer - If Yes, what type

Diabetes – state whether diet/tablet/insulin controlled

Asthma

Epilepsy

Hypothyroidism - taking Thyroxine

Chronic depression

Communication disorder – e.g. partially sighted/hard of hearing/asphasia

Have you had any other serious illnesses or operations not mentioned above:

Illness/Operation: Treatment: Date:

**FAMILY HISTORY**

## Have any close members of your family had:

Please specify Family member:

A heart attack below the age of 60 Yes/No

A heart attack above the age of 60 Yes/No

A stroke Yes/No

Diabetes Yes/No

Asthma Yes/No

Diagnosed with Cancer Yes/No

*If YES, what type?*

***Lifestyle Questions***

**SMOKING**

Which of the following applies to you (please circle one)

Never Smoked Ex Smoker Current Smoker

When did you stop? How many per day?

## **EXERCISE**

Healthy exercise usually involves activity that usually lasts for at least 20 minutes, raises your pulse and produces hard breathing. In younger people this might be running, cycling, aerobics or sport or brisk walk for older people.

How often do you exercise each week?

I cannot exercise because of disability

## **ALCOHOL**

How many units of alcohol do you consume in a week?

*1 unit = 1 glass of wine, half a pint of beer or a single pub measure of spirit)*

## **WOMEN ONLY**

## CONTRACEPTION

The practice is specialised in Family Planning Services. Would you wish the practice to provide you with contraceptive services and advice.

Yes No

## PREGNANCIES

Have you had any pregnancies Yes/No

If Yes how many and please give dates:

## CERVICAL SMEAR

When did you last have a cervical smear:

What was the result?

## MAMMOGRAM

When did you last have a mammogram:

What was the result?