Personal Details			
Address: Post Code:			D.O.B: / / NHS Number: Male ☐ Female ☐ Marital Status:
Telephone – Home			Occupation (Last job if retired)
Telephone – Mobile			
Telephone – Work			
Email:			**Next of Kin**
Reason for change of surgery			Name: Tel Number:

Personal Medical History				
Do you have/have had any of the following – (***Tick if appropriate)***				
ANGINA			HIGH BLOOD PRESSURE	
HEART ATTACK			DIABETES	
ATRIAL FIBRILATION			KIDNEY DISEASE	
HEART FAILURE			EPILEPSY	
STROKE			THYROID PROBLEMS	
MINI STROKE/TIA			DEMENTIA	
COPD			DEPRESSION	
ASTHMA			OTHER MENTAL ILLNESS	
******************IF YOU HAVE TICKED ANY OF THE ABOVE****************** ****************************PLEASE BOOK A NEW PATIENT MEDICAL****************************				
Other illness/Injuries:				
Operations:				
Disabilities:				
Current Medication: ***(Please provide a copy of your last repeat slip if you are taking regular medications)***				
Allergies;				
Current Problems Causing Concern:				

Immunisations	
Last Tetanus:	
Last Polio:	
Other Immunisations: ***(give details)***	
Family	
Partners Name:	
Children (Name & Age) _____ _____ _____ _____	

Females Only	
Contraception:	
Last Smear:	
Last Mammogram:	
Last Rubella Injection:	
Any Miscarriage/Still Births:	

Do You Smoke?			
Yes		Pipe/Cigar/Cigarettes ***(Delete as appropriate)***	
Used To		How Many Each Day	
Never		When Stopped	

Do You Drink Alcohol? YES/NO	If you have answered yes please complete the following questions					
Score	**0**	**1**	**2**	**3**	**4**	**Your Score**
How often do you have a drink that contains alcohol?	Never	Monthly or Less	2-4 Times Per Month	2-3 Times Per Week	4+ Times Per Week	
How many drinks do you have on a day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often do you have 6 or more drinks on one occasion?	Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily	
****************IF YOU HAVE SCORED 5 OR MORE**************** ***********************PLEASE BOOK A NEW PATIENT MEDICAL ***********************						

Do You Exercise?		Give Details of type of Exercise
(At least 30mins x 3/week) Regularly		
(Less than 30mins x 3/week)Occasionally		
Never		

Medical History of Family			
Has any close relative(parent/grandparent/brothers/sisters) had any of the following			
	YES	**NO**	**If Yes Who**
High Blood Pressure			
Angina/Heart Attack			
Stroke			
Asthma			
Diabetes			
Epilepsy			
Cancer			
Eczema/Hayfever			
Glaucoma/Blindness			
Sudden Death			

What Is Your Ethnic Group? (*Choose one section and tick the appropriate box)*		
WHITE		
British		Any Other White Background
MIXED		
White and Black Caribbean		Any Other Mixed Background
White and Black African		
White and Asian		
ASIAN OR ASIAN BRITISH		Any Other Asian Background
Indian		
Pakistani		
Bangladeshi		
BLACK OR BLACK BRITISH		Any Other Black Background
Caribbean		
African		
CHINESE OR OTHER ETHNIC GROUP		Any Other Please Specify
I refuse to answer this question		

Would you be interested in being contacted for your view on the services provided by the Surgery in the future? **YES / NO** ***(Delete as appropriate)***

If you wish to register for online services please ask at Reception.