**Personal Details**

**Surname:** **First Name(s)**

**Maiden Name:** **Parent/Guardian Name:**

**Date of Birth:** **Date:**……………………

**Address:**

**Postcode:**

**Home Telephone NO.:** **Work Telephone NO.:**

**Mobile Telephone NO.:** **Email Address:**

**Occupation:**

**Country of Origin:** **Ethnic Group:**

**Marital Status:**

**Next of Kin:** **Next Of Kin Relationship:**

**Next of Kin Address:**

**Postcode:**

**Next Kin Telephone NO.:**

**Previous Doctor Name and Address:**

Please check the appropriate box if you *do/ do not wish* to receive information regarding appointment reminders & heath checks by SMS (any patients over 14 will need to give their own consent) **YES NO (If left blank you will be opted out)**

Please check the appropriate box if you *do/ do not wish* to receive voicemail messages regarding your healthcare by

SMS (any patients over 14 will need to give their own consent) **YES NO (If left blank you will be opted out)**

**Medical Information**

**NO YES**

**Do You Have a Carer?**   (If Yes Please Provide Carers Name and Contact NO.:)

**Are You a Carer?**   (If Yes who for i.e. friend/mother etc:)

Do You Suffer From Any Of The Following Conditions:

**Allergies Drug**   (If Yes From What Drugs:)

**Allergies Food**   (If Yes From What Foods:)

**Angina**   (If Yes From What Date/Year:)

**Arthritis**   (If Yes From What Date/Year:)

**Asthma**   (If Yes From What Date/Year:)

**Anxiety/ Depression**   (If Yes From What Date/Year:)

**Bowel Disorder**   (If Yes From What Date/Year:)

**COPD**   (If Yes From What Date/Year:)

**Diabetes**   (If Yes From What Date/Year and **Type 1 or 2**:)

**Eczema/ Dermatitis**   (If Yes From What Date/Year:)

**Epilepsy**   (If Yes From What Date/Year:)

**Hay Fever**   (If Yes From What Date/Year:)

**Heart Failure**   (If Yes From What Date/Year:)

**High Blood Pressure**   (If Yes From What Date/Year:)

**Mental Health Conditions**   (If Yes From What Date/Year And Condition:)

**NO YES**

**Psoriasis**   (If Yes From What Date/Year:)

**Thyroid Disease**   (If Yes From What Date/Year:)

**Please List Any Other Conditions That Are Not Mentioned**:

**General Information**

**Height Feet & Inches or CM Weight Stones/KGs**

**Smoking Status - Cigarette/Cigar/Pipe**

**NO YES**

**Current Smoker**   (If Yes From What Date/Year And Number Per Day:)

**EX-Smoker**   (If Yes From What Date/Year Stopped:)

**Never Smoked**

**Alcohol Intake Wine Beer Spirits**

**Number Of Units Consumed Per Week**

***Small Glass = 1unit 1 Pint = 2 units 1 Measure (pub) = 1 unit***

**Medium = 2 units Home = 2 units**

**Large = 3 units**

**Exercise**

**What type of exercise are you involved with:** General Running  Swimming  Aerobic  Cycling Other

**Other Than General How Many Times Per Week Do You Do This:** 1 2 3 4 5+

**Please List Any Medication You Are Currently Taking – *(Alternatively please hand in your repeat slip from last practice)***

**Name Of Drug Dose /Strength Reason**

**Immunisation History**

**Do You Know The Date/Year You Received**: Tetanus: ………………….. Any Other:

**Family History**

**Have Any Of Your Blood Relations Suffered From:** (*If Yes Please State the Relative And Age If Known*)

Heart Disease: Diabetes High Blood Pressure

Breast Cancer: Bowel Cancer: Stroke:

Other Serious Illness:

**Female Patients Only**

How many pregnancies have you had?

Do You Have Any Children **NO  YES** (If Yes Please State the Number And Ages)

Have You Had Any Miscarriages **NO  YES** (If Yes Please State the Number)

Have You Had A Hysterectomy **NO  YES** (If Yes Please State the Type and Year)

When Was Your Last Smear Test And Result: