**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: