|  |
| --- |
| **Please complete all pages in FULL using BLOCK capitals** |
|  |
| **Surname**: |       |
|  |
| **First Name(s)**: (in full) |       |
|  |
| **Previous Surnames**: |       |
|  |
| **Title**: | [ ]  Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other |       |
|  |
| **Gender**: | [ ]  Male [ ]  Female |
|  |
| **Date of Birth**: (day/month/year) |       |
|  |
| **Address**: |       |
|  |
| **Post Code**: |       |
|  |
| **Telephone Number**: |       | **Mobile Number**: |       |
|  |
| **Email Address**: |       |

|  |
| --- |
| **If you Need your Doctor to Dispense Medicines & Appliances:** |
|  |
| [ ]  | I live more than 1 mile (1.6km) “as the crow flies”, from the nearest Chemist / Pharmacy and would therefore like the Surgery to dispense my Medicines and Appliances |

|  |
| --- |
| **About Yourself:** |
|  |
| **Are you a carer?** | [ ]  Yes [ ]  No | **Are you Housebound?** | [ ]  Yes [ ]  No |
|  | (eg. you are physically unable to leave your home) |
| **Do you have a carer?** | [ ]  Yes [ ]  No |
|  |
| **If yes, please tell us the name & address of your****Carer**: |       |
|  |
| **Are you happy for us to contact your carer about you?** | [ ]  Yes [ ]  No |

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| **For Patients Aged 75 or Over**: (these are to help us assess if you may need additional clinical input) |
|  |
| **In general, do you have any health problems that require you to limit your activities?** | [ ]  Yes [ ]  No |
|  |
| **In general, do you have any health problems that require you to stay at home?** | [ ]  Yes [ ]  No |
|  |
| **Do you regularly use a stick, walker or wheelchair to get about?** | [ ]  Yes [ ]  No |
|  |
| **In case of need, can you count on someone close to you?** | [ ]  Yes [ ]  No |
|  |
| **Do you need someone to help you on a regular basis?** | [ ]  Yes [ ]  No |
|  |
| **Please provide details if the person is different from the information you have provided as your carer.** |       |

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| **Disabilities / Personal Medical History ……** |
|  |
| **Do you have any disabilities or have you ever suffered from any important medical illness, operation or admission to hospital that you wish to inform us of?****If so please enter the details below**: |
|  |
| **Condition** | **Year Diagnosed** | **Ongoing** |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |

|  |
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| **Family History ……** |
|  |
| **Have any close relatives (father, mother, sister, brother only) ever suffered from any of the following**: (please indicate who in the boxes) |
|  |
| **Heart Attack** | **Stroke** | **Diabetes** | **High Blood Pressure** | **Asthma** | **Glaucoma** | **Cancer** |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |

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| **Immunisations ……** |
|  |
| **Immunsation** | **Year** | **Immunisation** | **Year** |
| Tetanus |       | Polio |       |
| Typhoid |       | Yellow Fever |       |
| Hepatitis A |       | Hepatitis B |       |

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| **Current Medication ……** |
|  |
| If you have a copy of your repeat medications, please pass to Reception to copy |
|  |
| **Name of Medication** | **Strength** | **Dosage** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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| **Lifestyle ……** |
|  |
| **Height**: | **Weight**: | **Blood Pressure**: |
|       |       |       |
| **Lifestyle – Smoking ……** |
|  |
| **Do you Smoke?** | [ ]  Yes [ ]  No |
|  |
|  | **If yes, what do you****Smoke?** | [ ]  Cigarette [ ]  Cigars [ ]  Pipe |
|  |
| **How many Cigarettes / Cigars do you smoke daily?** | [ ]  <1 [ ]  1 to 9[ ]  10 to19 [ ]  20 to 39[ ]  40+ | **If you smoke a pipe, how many ounces do you smoke a week?** |       |
|  |
|  | **Would you like help to quit smoking?** | [ ]  Yes [ ]  No |
|  |
| **Are you an ex-smoker?** | [ ]  Yes [ ]  No | **If yes, when did you give up?** |       |

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| **Lifestyle – Alcohol ……** |
|  |
| **Do you drink Alcohol?** | [ ]  Yes [ ]  No | ***If yes, please answer the following questions***: |
|  |
| **How often do you have a drink that contains Alcohol?** | [ ]  Never | [ ]  Monthly or Less | [ ]  2 to 4 times per month | [ ]  2 to 3 times per week | [ ]  4+ times per week |
|  |
| **How many standard alcoholic drinks do you have on a typical day when you are** **drinking?** | [ ]  1 to 2 | [ ]  3 to 4 | [ ]  5 to 6 | [ ]  7 to 9 | [ ]  10+ |
|  |
| **How often do you have 6 or more standard drinks on one occasion?** | [ ]  Never | [ ]  Less than Monthly | [ ]  Monthly | [ ]  Weekly | [ ]  Daily or almost Daily |

|  |
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| **Lifestyle – Exercise ……** |
|  |
| **Do you Exercise?** | [ ]  Yes [ ]  No | ***If yes, please answer the following questions***: |
|  |
| **What exercise do you do?** |       | **How often do you exercise?** |       |

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| **Allergies ……** |
|  |
| **Please list any allergies you have to any Drugs / Medication**: |
|  |
| **Name of Medication** | **What was the Problem or Upset?** |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

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| **Ethnicity ……** |
|  |
| **Please indicate your ethnic origin**: |
|  |
| [ ]  British or mixed British | [ ]  Irish | [ ]  African | [ ]  Caribbean | [ ]  Indian | [ ]  Pakistani |
|  |
| [ ]  Bangladeshi | [ ]  Chinese | [ ]  Other (please state): |       |
|  |
| [ ]  Decline to State |

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| **Female Patients Only ……** |
|  |
| **Are you currently, or think you may be pregnant?** | [ ]  Yes [ ]  No |
|  |
| **Do you have any children?** | [ ]  Yes [ ]  No | **If yes, how many?** |       |
|  |
| **Which method of contraception (if any) are****you using at present?** |       |
|  |
| **Have you had a cervical smear test?** | [ ]  Yes [ ]  No | **If yes, what was the result?** (if known) |       |
|  |
| **Date?** (if known) |       |

|  |
| --- |
| **Next of Kin ……** |
|  |
| **Name**: |       | **Telephone Number**: |       |
|  |
| **Relationship**: |       |
|  |
| In the event of an Emergency can we contact your Next of Kin? | [ ]  Yes [ ]  No  |

|  |
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| **Communication Preferences ……** |
|  |
| **Where you have provided information on how to contact you, can you confirm you are happy for Bishops Waltham Surgery to contact you by the following**: |
|  |
| By E-Mail | [ ]  Yes [ ]  No | This will be to send you letters, newsletter, recalls and the like |
|  |
| By SMS Text Message | [ ]  Yes [ ]  No | This will NOT opt you out of appointment reminders sent via sms text messages |

|  |
| --- |
| **Signature ……** |
|  |
| **I confirm that the information I have provided is true to the best of my knowledge.** |
|  |
| **Signed**: |  | **Date**: |       |
|  |
| [ ]  Signature of Patient | [ ]  Signature on behalf of Patient |