|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 |

|  |  |  |
| --- | --- | --- |
| **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 | |