

**Ivel Medical Centre – Patient Information**

Date of Health Check .....

Name.....

Address.....

Date of Birth.....Telephone Number.....

Next of Kin..... Telephone Number .....

Relationship.....

What is your main language spoken? .....

**FAMILY HISTORY** (Including parents and grandparents)  
Have any members of your family suffered from the following?

Diabetes	Yes/No	Asthma	Yes/No	Heart Problems	Yes/No
Stroke	Yes/No	High Blood Pressure	Yes/No	Cancer	Yes/No

**GENERAL HISTORY**

What is your occupation? .....

Have you had any serious illnesses or operations? .....

Do you have any allergies? .....

Are you on any medication? YES/NO If yes please list.  
.....  
.....  
.....

Do you smoke? YES/NO If YES How many years? Amount per day?  
.....

If you are an ex-smoker. How many years? Amount per day?  
.....

How much alcohol do you consume per week?  
Wine .....Beer .....Spirits .....

How much exercise do you take each week? .....

When was your last tetanus vaccination? .....

Are you a Carer for another person? YES/NO

Do you have someone who cares for you? YES/NO

**Female Patients Only**

When was your last smear test? .....

Please tick relevant Contraception.

COIL      PILL      INJECTION      IMPLANT      PATCH

**Please hand this form to the nurse at your appointment**

**To be completed by the nurse**

Height ..... Urine ..... Diet .....

Weight ..... B/P ..... Rubella Status .....

Chlamydia Screening Urine Test.....

**If Patient aged between 16 and 24 offer a Chlamydia screening Urine Test (see kits); patient must not have passed urine in the last hour.**

**If Patient on medication give Practice Repeat Prescribing Leaflet.**

**If the person is a Carer ask them to complete Carer Form and pass this form to the Office Manager.**

**If the person is cared for establish if Carer is registered at Practice. Pass details to Office Manager.**