**YOUR DETAILS**

|  |  |
| --- | --- |
| Name: | Date Of Birth: |
| Address: |  |
|  |
|  |
| Postcode: |
| Home Telephone No: | Mobile No: |

**YOUR NEXT OF KIN**

|  |  |
| --- | --- |
| Name: | Date Of Birth: |
| Relationship: |  |
| Address: |  |
|  |
|  |
| Postcode: |
| Home Telephone No: | Mobile No: |

**YOUR PERSONAL DETAILS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Marital Status | Single | Married | Co-Habiting | Divorced | Widowed | Other |
| Ethnic Group  |  |
| Interpreter Needed? | Yes / No If yes, language: |
| Smoking Status | Current Smoker | Number of cigarettes per day: |
| Ex-Smoker | Date stopped: |
| Never Smoked |  |
| Alcohol Status | Currently Drink | Number of units per week:\_\_\_\_ **OR** drink rarely  |
| Stopped Drinking | Date stopped: |
| Never Drank |  |
| Height |  |
| Weight |  |
| Are you a Carer? | Yes / No (If yes please ask for a carer pack at Reception Desk) |

**YOUR MEDICAL HISTORY (i.e. any current investigations/symptoms and any previous medical diagnosis such as skin condition, asthma, diabetes, heart condition, cancer, etc)**

|  |  |
| --- | --- |
| Event Date | Details  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**YOUR SURGICAL HISTORY**

|  |  |
| --- | --- |
| Event Date | Procedure  |
|  |  |
|  |  |
|  |  |
|  |  |

**FAMILY HISTORY (please do not include your own medical history in this category)**

|  |  |
| --- | --- |
| Hypertension | Yes / No Relation(s): |
| Heart Disease | Yes / No Relation(s): |
| Diabetes | Yes / No Relation(s): |
| Stroke | Yes / No Relation(s): |
| Asthma  | Yes / No Relation(s): |
| COPD | Yes / No Relation(s): |
| Cancer – please specify which type | Yes / No Relation(s): |
| Other – Please specify |  |

**ALLERGIES**

|  |  |
| --- | --- |
| Drug Allergies |   |
| Non-Drug Allergies (food, pets etc) |  |

**IMMUNISATION RECORD (please complete if you are moving to this practice from outside the UK)**

|  |  |  |  |
| --- | --- | --- | --- |
| Immunisations | DTP/POLIO/HIB/MEN C/MMR | Booster | DT/POLIO/MMR |
| Others (Please circle and date if known) | RUBELLA TB OTHER:HEP A/HEP B TYPHOIDTETANUS POLIO |

**MEDICATIONS if you are on repeat medication from your previous GP please attach a copy of your repeat order slip and complete the table below**

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dosage of Medication (i.e. 5mg) | Regimen (i.e. once daily) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**FEMALES ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| Contraception: |  | Sterilisation: | Yes / No |
| Last Smear Date: |  | Hysterectomy:  | Yes / No If yes, date:  |