PATIENT DETAILS

To help us to provide you with the best possible care we would be grateful if you would take the time to answer **All** the following questions.

|  |  |
| --- | --- |
| Surname: | Title: Mr/Mrs/Miss/Ms/Dr/Other |
| Forenames: | |
| Date of Birth: | Previous Surname: |
| Address: | |
| Post Code: | Home Phone: |
| Email: | |
| Mobile Phone: | Work Phone: |
| Do you consent to receive:  SMS notifications for clinical services. Yes No  E-mail notifications for clinical services Yes No | |

|  |
| --- |
| What is your language? |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Were you previously registered at the practice? | | Yes No | | | |
| Who would you like to be registered with? | Dr Hickman | | Dr Winter | Dr Sutcliffe | No preference |

|  |  |
| --- | --- |
| Height: | Weight: |

|  |  |
| --- | --- |
| Are you a Carer? | Unpaid Employed |
| If Unpaid, whom do you care for? | |
| Are they registered at North Curry Health Centre? Yes No | |

### MEDICAL HISTORY – Only complete this section if you are a new patient to the surgery

|  |
| --- |
| **Past Medical History:** Please state any on-going illnesses, or disabilities, or any significant past illness, operations, accidents and the year when they happened or started. |
| **Current Medication:** Please list medications that you are taking at the present time and the dosage (or preferably attach a prescription list from your previous GP) |
| **Allergies:** Please state any allergies that might affect your treatment |

**NEXT OF KIN**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Are they registered with us?** | | | **Y ☐ N ☐** | **Relationship with you?** |  | |
| **Their Full name** |  | | | | | |
| **Their Contact number** | |  | | | **Their DOB:** | / / |

**FAMILY HISTORY**

Have any of your parents, brothers or sisters had either of the following? If so please state at what age and what relative:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Condition** | **Yes** | **No** | **Relative** | **Age** |
| Angina |  |  |  |  |
| Myocardial Infarction (Heart Attack) |  |  |  |  |
| Diabetes |  |  |  |  |
| Other: |  |  |  |  |

**BLOOD PRESSURE**

**If you do not have access to a Blood Pressure machine there is a machine at the surgery in the waiting room.**

|  |  |  |
| --- | --- | --- |
| **Date taken** | **Pulse** | **Blood pressure** |
|  |  |  |

**WOMEN ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have?** | **YES** | **NO** | **Name of Coil** (e.g. Mirena) | **Date due for replacement** |
| A Coil |  |  |  |  |
| A Contraceptive Implant |  |  |  |  |

**LIFESTYLE INFORMATION**

**ALCOHOL**

It would be helpful if you could complete the following ‘FAST’ alcohol screening test by circling the most appropriate answer(s). it has been suggested that if your score is 3 or more you may wish to discuss and review your alcohol consumption further.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Scoring** | | | | |
| **0** | **1** | **2** | **3** | **4** |
| How often do you have:  **MEN:** 8 or more *standard\** drinks on one occasion?  **WOMEN:** 6 or more *standard*\* drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last 6 months have you been unable to remember what happened the night before because you were drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| How often during the last 6 months have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| In the last 6 months has a relative, friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

*\* One standard drink (1 unit) is:*

*One small glass or wine*

*Half a pint or regular beer, lager or cider*

*One small glass of sherry*

*One single measure of spirits*

*One single measure of aperitifs*

|  |  |  |  |
| --- | --- | --- | --- |
| **Exercise:** Would you describe yourself as: (please tick) | | | |
| Very Active | Active | Lightly Active | Inactive |

**SMOKING** *(Please complete the section in Yellow if you have previously smoked or if you currently smoke)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **I am a non-smoker\* ☐** | | **I do smoke tobacco** | | | |
| Never been a smoker |  | Cigarette Smoker |  | No per day |  |
| Ex-Cigarette Smoker |  | Roll-Up Cigarette Smoker |  | No /gms per week |  |
| Ex-Pipe Smoker |  | Cigar Smoker |  | No per day |  |
| Ex-Cigar Smoker |  | Pipe Smoker |  | gms per week |  |

*If your only smoking experience is teenage experimentation we think it is reasonable to class yourself as never having been a smoker*

**Are you a Smoker and want to give up? Did you know that stopping smoking support and nicotine replacement treatment makes giving up much more successful? Ask at reception for information about stopping smoking support.**

|  |  |
| --- | --- |
| (For Office Use Only) EMIS NO: |  |
| ID seen by: | Photo ID ☐ Proof of residence seen ☐ |