PATIENT INFORMATION

The completion of this form is a mandatory requirement whenever patients change their Doctors. Thank-you for taking the time to complete it. ***Please hand in this form to the Receptionist – Please fill in as much as you can. Please be as accurate as you can in all areas.***
Please note: If you have been advised to make an appointment (due to your medication or past medical history) then please keep this appointment. If you fail to do so, then it will affect the quality of care we can provide.

Date:…………………..Surname:……………………………………First Name:…………..……………………………..

Other Name(s):…………………………………..……………………………………..…………………………………….

Full Address:………………………………………………………………………..……………………………………..

Date of Birth:…………………………………………Marital Status:………………………..………………………….

Sex: Male / Female …………………Occupation:…………………………………………..…………………………..

Telephone No (Home) :……………………..………(Work) ………….….……….(Mobile)……………………………….

Email:………

Next of Kin : Name:………………………………Telephone No:……………………………………………

Other Carers: Name:……………………………… Telephone No: ………………….……………...………

Race / Ethnicity: **To which of these ethnic groups do you feel you belong to?**

Please tick one box, or if you feel none of the choices suit you, write your ethnic group in the 'any other' space.

WHITE	BLACK OR BLACK BRITISH	CHINESE OR OTHER ETHNIC
❑ British ❑ Irish ❑ Any other White background please state:	❑ Caribbean ❑ African ❑ Any other Black background please state:	❑ Chinese ❑ Vietnamese
ASIAN OR ASIAN BRITISH ❑ Indian ❑ Pakistani ❑ Bangladeshi ❑ Any other Asian background please state:	MIXED ❑ White and Black Caribbean ❑ White and Black African ❑ White and Asian ❑ Any other mixed background please state:	**Any other ethnic group; please write below:** **Place of birth /Town / Village / Country**

GENERAL HISTORY – ***Have you ever suffered from any of the following?***

If you answer 'yes' to any questions then you must make an appointment to see a doctor	Please indicate 'Yes'	'No'		Please indicate 'Yes'	No'
Epilepsy			**Chronic bronchitis/ Emphysema**		
Heart Disease			**Thyroid disease**		
Asthma			**Schizophrenia/manic Depression**		
Cancer			**Stroke**		
Diabetes			**High blood pressure**		

Other serious illness, or operations with dates:

- ***What medicines are you currently taking:***

  1………………………………………………………………….. 2………………………………………………………………
  3……………………………………………………………… …. 4………………………………………………………………
  5……………………………………………………………….. 6………………………………………………………………
  7……………………………………………………………….. 8………………………………………………………………

  Have you any allergies to medicine or anything else?...

  If you need a further prescription for your regular medication, you must make an appointment to see a doctor
- How much tobacco or cigarettes do you smoke?……………………………………………………………
- How much alcohol do you consume per week? (Quantity)?
- Wine………………………….. Beer…………………………… Spirits…………………………

FOR FEMALE PATIENTS ONLY:

- When was your last smear test? (date):………………………..Was it a normal result? Yes / No
- Have you had a hysterectomy? (date)…………………………..

IMMUNISATIONS

- Last Tetanus booster date:……………………………..
- Last 'Flu' booster date:…………………………………
- Last Pneumonia booster date:………………………….
- Have you had any travel immunisations in the last 10 years, eg. Hepatitis A, Typhoid, Yellow fever, Meningitis……………………………………………………………………………………...

CHILDHOOD VACCINATIONS (FOR CHILDREN UP TO THE AGE OF 10 YEARS)

Please give the approximate date for the vaccinations you have had:

1st DTP, Polio, Hib, Pneumonia (usually given aged 1 month)……………………………………………..
2nd DTP, Polio Hib, Meningitis C (usually given aged 2 months)………………………………………………
3rd DTP, Polio, Hib, Meningitis C, Pneumonia (usually given aged 3 months)………………………………………………
MMR (usually given ages 12-18 months)……………………………………………………………………
DTP, Polio, MMR…………………………………………………………………………………………
(Pre-school boosters, usually given aged 4 ½ years)

FAMILY HISTORY

Are there any major illnesses that run in your family?
Eg. Heart Disease, Asthma, Cancer, Diabetes, Stroke
Which illness(es):……………………………………. What dates?……………………………………………
Family Connection:…………………………………………………………………………………………

THANK YOU FOR YOUR CO-OPERATION IN COMPLETING THIS FORM

BP **weight** **height** **Urine dipstick**

Date of doctors appointment:………………………..
(if applicable)

ALCOHOL QUESTIONNAIRE
(For patients aged 16 or over)

1. How often do you have a drink containing alcohol?

Answer	points
Never	0
Monthly or less	1
2-4 times a month	2
2-3 times a week	3
4 or more times a week	4

2. How many standard drinks containing alcohol do you have on a typical day?

Answer	Points
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4

3. How often do you have six or more drinks on one occasion?

Answer	points
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

For men, if your score is higher than 4 then you may be at risk from your drinking
For women, a score of 3 or more is considered positive

If you have high scores then please feel free to make an appointment with a Doctor to discuss these issues