*Please fill in this form to the best of your ability. It will help us until we receive your medical record and acts as a useful aid to your healthcare.*

|  |  |
| --- | --- |
| Name |   |
| Date of Birth |   |
| Address |   |
|   |   |
|   |   |
|   |   |
|   |   |

|  |  |
| --- | --- |
| Home Telephone Number |   |
| Mobile Telephone Number |   |
| Work Telephone Number |   |
| Email Address |   |
|  |  |

What is your Marital Status?

|  |
| --- |
| Single |
| Married/Civil Partner |
| Divorced/Civil Partnership Dissolved |
| Widowed/Surviving Civil Partner |
| Separated |

Do you have children below 16 years old in your household?

|  |  |
| --- | --- |
| Yes | No |

Do you wish to be exempted from the practice sending you text messages (appointment reminders, etc.)?

|  |  |
| --- | --- |
| Yes | No |

Do you have access to a car?

|  |  |
| --- | --- |
| Yes | No |

Do you have a nominated pharmacy for electronic prescriptions?

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Your occupation/s |   |
| Partners occupation/s |   |
| If unemployed please state for how long? |   |
| If there are children in your household below 16 years old that you are the parent/guardian of, please write their name/s and date of birth/s here: |   |

**Military Questionnaire**

Are you a military veteran/ex-service personnel?

|  |  |
| --- | --- |
| Yes | No |

Do you wish for this to be recorded in your notes?

|  |  |
| --- | --- |
| Yes | No |

**NHS England: Summary Care Record**

Summary Care Records are used in emergency care and contains information such as any medication you are taking, allergies that you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.

***If you would like to opt out of having a Summary Care Record then please ask for the opt-out form at reception. For more information regarding Summary Care Records you can call the dedicated NHS Summary Care Record Information Line on 0300 123 3020 or visit www.nhscarerecords.nhs.uk.***

**Health Questionnaire**

Current Medication

|  |
| --- |
|   |
|   |
|   |
|   |
|   |
|   |

Are you allergic to any drugs?

|  |
| --- |
|   |
|   |
|   |
|   |
|   |
|   |

Please tick if you have had any of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Anaemia |   | Epilepsy |   |
| Asthma |   | Heart Disease |   |
| Chronic Bronchitis or Emphysema |   | Mental Illness/Depression |   |
| Diabetes |   | Peptic/Gastric/Duodenal Ulcer |   |
|  |  |  |  |
| Operations (Please Give Details) |   |  |   |

Have you ever smoked?

|  |  |
| --- | --- |
| Never Smoked |   |
| Ex-Smoker |   |
| Smoker |   |

How many units of alcohol do you drink a week on average?

|  |
| --- |
|  |

If you selected smoker, then what kind of smoker?

|  |  |
| --- | --- |
| Cigar |  |
| Cigarettes |   |
| E-Cigarettes |   |
| Pipe |   |

For Women: What was the year of your last Cervical Smear

|  |
| --- |
|  |

**Family History Questionnaire (Blood Relatives Only)**

If parents, brother, sister or children have died, their age and cause of death:

|  |
| --- |
|   |
|   |
|   |
|   |
|   |
|  |

Have any blood relatives had any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Coronary Thrombosis (Heart Attack) |   | Angina |   |
| High Blood Pressure |   | Stroke |   |
| Asthma, Eczema, or Hay Fever |   | Diabetes |   |
|  |  |  |  |
|  |  |  |  |

**Patient Ethnic Origin Questionnaire**

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

|  |  |  |
| --- | --- | --- |
| White | British |   |
|   | Irish |   |
|   | Any Other White Background |   |
| Mixed | White and Asian |   |
|   | White and Black African |   |
|   | White and Black Caribbean |   |
|   | Any Other Asian Background |   |
| Asian or Asian British | Bangladeshi |   |
|   | Indian |   |
|   | Pakistani |   |
|   | Any Other Asian Background |   |
| Black or Black British | African |   |
|   | Caribbean |   |
|   | White and Asian |   |
|   | Any Other Black Background |   |
| Chinese or Other Ethnic Group | Chinese |   |
|   | Any Other Background |   |

**Carer Questionnaire**

Are you a carer?

|  |  |
| --- | --- |
| Yes | No |

If so, who for?

|  |  |  |
| --- | --- | --- |
| Elderly Relative | Relative with Disability | Other |

If you selected Other, please record relationship

|  |
| --- |
|  |

Do you wish for this to be recorded in your noted?

|  |  |
| --- | --- |
| Yes | No |

For Official Use Only:

Accepted By: ……………………………………………………………………………………………………………………………………………………

Date Accepted: ………………………………………………………………………………………………………………………………………………..

Identification Type: ………………………………………………………………………………………………………………………………………….

Proof of Address Type: ……………………………………………………………………………………………………………………………………

Processed By: …………………………………………………………………………………………………………………………………………………..