

Your Name:	Date of Birth:	
	<p>Ethnic Origin: Please tick <u>one</u> box from the following selection to indicate your cultural background.</p> <p> <input type="checkbox"/> 1. White British <input type="checkbox"/> 2. White Irish <input type="checkbox"/> 3. Traveller of Irish Heritage <input type="checkbox"/> 4. Gypsy/Roma <input type="checkbox"/> 5. White & Black African <input type="checkbox"/> 6. White & Black Caribbean <input type="checkbox"/> 7. White & Asian <input type="checkbox"/> 8. Any other White Background </p>	<p> <input type="checkbox"/> 9. Indian <input type="checkbox"/> 10. Pakistani <input type="checkbox"/> 11. Bangladeshi <input type="checkbox"/> 12. Any Other Asian Background <input type="checkbox"/> 13. Caribbean <input type="checkbox"/> 14. African <input type="checkbox"/> 15. Chinese <input type="checkbox"/> 16. Any other (please specify): _____ </p> <p>First Language: Please Specify below: _____</p>
Your Address:	Email Address:	
	Mobile No:	
	Are you happy to be contacted by these methods above? (Please Circle)	
	Yes No	
	Work No:	
	Tel No:	
	Post Code:	
Next of Kin: (Name & Address)	Contact Number: <i>(for next of kin)</i>	
	Relationship to you:	
Are you housebound? (Please Circle)	Yes	No
Do you have a carer?	Name of Carer:	
<i>If yes please give details.</i>	Address:	
	Contact Number:	
Are you a carer?	Name of person you care for:	
<i>If yes please give details of who you care for.</i>	Address:	
	Contact Number:	
Do you have any special needs?		

CLINICAL INFORMATION (Please fill in as appropriate.)

Height		Weight	
Have you ever smoked?	Yes No	Ex-smoker ?	
Current Smoker?	Yes No	Amount & Date Stopped	
Do you wish any help to stop smoking?	Yes	No	

Current Medication (Please list below)	Allergies (Please list below)
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Chemist Collection (Specify which chemist you would like to collect your prescription from)

From the Surgery Boots Ross (Bishopteington)
 Orchid/Moss (Opposite Surgery) Buckland Day Lewis
 ASDA Franklands (Queen Street) Superdrug

Do you drink alcohol?	If yes approximately how many units per week? (1 unit = 1/2 pint beer/ 1 measure spirits/ 1 small glass wine)	
Do you take any regular exercise?	If yes what type	
	Light (ie Gardening)	
	Moderate (ie Swimming, Tennis)	
	Heavy (ie Weight Training)	

GENERAL HEALTH Do you currently suffer with any of the following conditions?
(Please circle as appropriate)

Diabetes Asthma Stroke High Blood Pressure Cancer	Heart Disease Angina Heart Attack	If yes to heart attack please give approximate date.
Other (Please specify)		

DO ANY FAMILY MEMBERS SUFFER FROM ANY OF THE FOLLOWING CONDITIONS? (Please circle as appropriate)

Stroke	High Blood Pressure	Diabetes
Heart Disease	High Cholesterol	Cancer

FOR FEMALES ONLY (Please tick as appropriate)

Are you currently using any form of contraception?		Are you Pregnant?	
Are you taking any form of HRT?		Have you had a hysterectomy?	
Have you had a cervical smear within the last 3 years?		(If yes please give approximate date)	

Date completed by patients