Please take a few minutes to complete the information below

Patient Name:		DOB:	

Occupation:	

Gender :	Male		Self Identifying	
	Female		Prefer not to say	

Pronouns:	He/Him		She/Her		They/Them	

If you wish to discuss in person, please feel free to make appointment

Would you like to receive text message from the practice?	YES	NO

Mobile Telephone Number:	

Are you housebound?	YES		NO	

Are you currently attending the hospital for ongoing medical treatment or assessment?				
	YES		NO	

If yes please ensure you have advised them of your change of address and new GP

Are you attending regularly for blood monitoring for any reason?				
	YES		NO	

Do you receive any regular injections?	YES		NO	
If YES, can you tell us the nature of these injections:				

Height:		Weight:	

Previous Illnesses: (With dates if possible)	

Previous Operations: (With dates if possible)	

Date of last polio vaccination:	
Date of last tetanus vaccination:	

Do you take any tablets or medicine? (If so please sate frequency and dosage)		
Drug	Dosage	Frequency

Are you allergic to any drugs? (Please detail below)	
Drug	**Symptoms**

Do you have any other allergies?	YES		NO
If YES, please detail:			

Do you care for an elderly or frail relative, neighbour or friend?				
	YES		NO	

Please provide details of your next of kin.

Next of kin:	Relationship:
Address of next of kin:	
Next of kin contact telephone number:	

Family History

Raised Cholesterol		Heart Disease	
Stroke		Diabetes	
Raise Blood Pressure		Other	

Lifestyle

Never smoked	Ex smoker	current smoker	E-cigarette smoker

Do you drink alcohol?	YES		NO	

If YES do you drink alcohol; daily weekly monthly occasionally

How often do you exercise weekly; 0 1 2 3+

Do you drive professionally?

HGV		PSV		OTHER	

Women Only

Number of pregnancies or miscarriages:				
	Pregnancies		Miscarriages	

Date of last Cervical Smear:	

Signature:		Date:	