

PERSONAL DETAILS			
SURNAME		DATE OF BIRTH	
FORENAMES		MARITAL STATUS	
ADDRESS			
POSTCODE		TEL NO (WORK):	(HOME):
OCCUPATION		ETHNIC ORIGIN:	
EMERGENCY CONTACT NAME	FIRST LANGUAGE:		
EMERGENCY CONTACT TEL:		WILL YOU REQUIRE AN INTERPRETER?	

We need to ask questions about where you lived in the past. This information will not be used in any way for immigration purposes, but is purely used to determine whether or not you need to be screened for the infectious disease Tuberculosis

Are you a new entrant to the UK in the last five years? Yes No

Were you born or have you lived or worked for more than one month in any country other than Canada, USA, Northern Europe, Australia or New Zealand? Yes No

Which countries?

MEDICAL HISTORY

- Have you ever been in hospital for anything at all? (ie. Investigation / operation)
- If yes, please state **when** and for what.

- Have you had any medical illnesses/problems you have needed to see your doctor regularly for?
- If yes please give details, including dates.

- Do you suffer/have you suffered in the past from any of the following? (please tick)

ASTHMA	DIABETES	EPILEPSY
HIGH BLOOD PRESSURE	CANCER	BRONCHITIS / PNEUMONIA

MEDICINES

- Please list any medicines, tablets or contraceptive pills you use regularly

MEDICINE	DOSE PER DAY

FAMILY HISTORY

- Does anyone in your family suffer from (presently / in the past) any of the following? Please tick and state how old **they** were at the time

	Mother	Father	Sister	Brother
HEART ATTACK				
DIABETES				
STROKE				
ASTHMA				
HIGH BLOOD PRESSURE				
CANCER (please state type)				

Are you aware of these conditions in other members of your family (Please state which)

ALLERGIES

- Are you allergic to any medicine or any other substances? Eg pollen, nuts, other foods
- If yes please give details

VACCINATIONS

- What date, approximately, did you last have the following? Please list any others you have had.

TETANUS --

POLIO --

LIFESTYLE

- Do you smoke? Yes No If Yes how many?
- Please state type (cigs, cigars, tobacco)

- Have you ever smoked? Yes No If Yes how many and when did you stop?

- Do you drink alcohol? Yes No If Yes how many units per week?
- 1 unit = 1 glass wine; 1 measure of a spirit, half a pint of lager

- What is your height?

- What is your weight?

- Is your diet balanced and healthy?

BMI: (practice to record)

- How often do you exercise for 20 minutes or more at a time? (including brisk walking)

- What type of exercise is it?

Patient records are held on computer as well as paper. GPs are responsible for the confidentiality of these records. On occasions we share information from the patient records with the Health Authority, Primary Care Trust, hospitals and other NHS/partner organisations in the interests of patient care.

I agree to my medical records being held under the above terms and I certify that the information I have provided is correct to the best of my current knowledge.

Name:..... Signature Date:.....

WOMEN ONLY SECTION

IT IS VERY IMPORTANT THAT YOU COMPLETE THIS SECTION SO THAT WE HAVE AN ACCURATE SMEAR RECORD FOR YOU IMMEDIATELY

- How many times have you been pregnant?
- How many deliveries have you had?
- Type: (eg normal, caesarean): State if premature (how many weeks?):
- Any problems? (eg raised blood pressure)

- Date of last cervical smear test
- Where was the test taken? Please tick...

GP	<input type="checkbox"/>	HOSPITAL	<input type="checkbox"/>	ABROAD	<input type="checkbox"/>
FAMILY PLANNING CLINIC	<input type="checkbox"/>	PRIVATE	<input type="checkbox"/>	OTHER	<input type="checkbox"/>

- What was the result? Please tick....

NORMAL , routine recall - 3 years	<input type="checkbox"/>	ABNORMAL	<input type="checkbox"/>
NORMAL , early recall - 1 year	<input type="checkbox"/>	BORDERLINE CHANGES , recall – 6 months	<input type="checkbox"/>
NORMAL , early recall - 6 months	<input type="checkbox"/>	INADEQUATE , recall – 3 months	<input type="checkbox"/>

- If Abnormal are you currently having treatment? Yes No
- Have you had an abnormal smear in the last 10 years? Yes No

- I DO NOT REQUIRE CERVICAL SCREENING SERVICES (i.e. Due to hysterectomy, never sexually active etc.)
- If you have had a total hysterectomy please give:
Reason:
Date:

Have you got an IUCD or IUS (Intrauterine contraception device, coil or Mirena)? Yes No
If so, when was it fitted? (Month and Year)

Are you having problems with it (bleeding, pain, increased vaginal discharge)? Yes No
Please note that if you are having problems, we would like you to make an appointment with a GP to discuss them

When did you last have it checked? (this is not usually necessary after your 6 weeks post fitting check, unless you are having problems, or feel uncomfortable feeling for the threads yourself)

PLEASE NOTE: IUCD and IUS's should be usually be changed or removed after 5 years

Are you currently using contraception?

If so what type?

If you are between 50 – 70, when did you last have a mammogram?