|  |  |  |  |
| --- | --- | --- | --- |
| **TITLE** |  | **SURNAME** |  |
| **FORENAME(S) NAME:** |  | **DOB:** | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| **ADDRESS** |  |
| **HOME NO:** |  | **MOBILE NO:** |  |
| **E-MAIL ADDRESS** |  |
| **STATUS** | Single □Married □Separated □ | Divorced □Widowed □Other □ |
| **ARE YOU A VETERAN?** | YES □ / NO □ | If “YES”, please (✓)select the relevant option | Army veteran □ Military veteran □Royal Navy veteran □ Royal Marines veteran □Royal Air Force veteran □  |
| **TYPE OF HOUSING**Please (✓) select the appropriate option | House □Flat □ | Bungalow □Maisonette □ | Mobile home □Other □ |
| **SMOKING STATUS** |
| ARE YOU A CURRENT SMOKER ? | YES □ / NO □ | If “YES”, how many per day? |  | How long have you been smoking for? |  |
| ARE YOU AN EX-SMOKER? | YES □ / NO □ | If “YES”, how many years did you smoke for? |  | When did you stop? |  |
| **DO YOU DRINK ALCOHOL?**YES □ / NO □*If “YES”, how much do you drink per week?* | ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
|  |  |  |
| **DO YOU EXERCISE?**YES □ / NO □If “YES”, what sort of exercise do you take? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ARE YOU A CARER?** | YES □ / NO □ |  |
| **DO YOU HAVE A DISABILITY:** YES □ / NO □*If “YES”, please ✓ the relevant box*  |
| * Deaf □
 | * Deaf /Mute□
 | * Blind□
 | * Learning Disabilities□
 |
| * Other □ *Please specify*
 |
| **If you answered “YES” to any of the above, how can we best support you in using our services?**  |
| Text Messages □ | E-mail □ | Fax □ | Large Print□ |
| Hearing Loop □ | Video Consultations □ | Sign Language interpreter □ |
| **FAMILY HISTORY OF THE FOLLOWING CONDITIONS:-**  |
| *Please ✓ the appropriate box* | **Heart Disease** | **Diabetes** | **Stroke** | **Asthma** |
| Yourself |  | Age \_\_\_\_\_\_\_ | Do you have? |  |  |  |  |
| Father | Alive □Deceased □ | Age \_\_\_\_\_\_\_ | Current □Past □ |  |  |  |  |
| Mother | Alive □Deceased □ | Age \_\_\_\_\_\_\_ | Current □Past □ |  |  |  |  |
| Brother (s) | Alive □Deceased □ | Age \_\_\_\_\_\_\_ | Current □Past □ |  |  |  |  |
|  | Alive □Deceased □ | Age \_\_\_\_\_\_\_ | Current □Past □ |  |  |  |  |
| Sister (s) | Alive □Deceased □ | Age \_\_\_\_\_\_\_ | Current □Past □ |  |  |  |  |
|  | Alive □Deceased □ | Age \_\_\_\_\_\_\_ | Current □Past □ |  |  |  |  |
| **ARE THERE ANY OTHER DISEASES THAT AFFECT ANY MEMBERS OF YOUR FAMILY?** | YES □ / NO □ | If “YES”, please provide details: |  |
| **HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS?** YES □ / NO □ *If “YES”, please list below* |
| OPERATION / ILLNESS | DATE OF OPERATION / DIAGNOSIS |
|  | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
|  | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| **DO YOU HAVE ANY MEDICAL PROLEMS AT THE MOMENT?** YES □ / NO □*If “YES”, please list below* |
|  |  |
|  |  |
|  |  |
| **ARE YOU ON ANY MEDICATION?** YES □ / NO □*If “YES”, please list and give full details below* |
|  |  |
|  |  |
|  |  |
| **DO YOU HAVE ANY KNOWN ALLERGIES?**YES □ / NO □ *If “YES”, please list below* |
|  |  |
| **DETAILS OF IMMUNISATION YOU HAVE HAD:** *Please ✓ where applicable and provide a date of immunisation*  |
| DIPTHERIA | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| TETANUS | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| PERTUSSIS [whooping cough] | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| HIB | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| POLIO | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| MMR | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| RUBELLA | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| PSB(Pre-school booster) | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| MEN C | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| PNEUMOCOCCAL | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| ROTAVIRUS | YES □ / NO □ | If “YES”, when? | \_\_\_/\_\_\_ / \_\_\_\_\_\_ |
| OTHER | YES □ / NO □ | If “YES”, please specify: |
|  |  |  |
| **ARE YOU ON ANY SPECIAL DIET:** YES □ / NO □*If “YES”, please provide details below:*  |
|  |
| **FEMALES ONLY:**  |
| Date of last smear: \_\_\_/\_\_\_ / \_\_\_\_\_\_ | Result: |
| **ETHNICITY:** *Please ✓ the appropriate option* |
| **White*** English/Welsh/Scottish/Northern Irish/British
* Irish
* Gypsy or Irish Traveller
* Any other White background, please specify below:
 | **Mixed / Multiple ethnic groups*** White and Black Caribbean
* White and Black African
* White and Asian
* Any other Mixed / Multiple ethnic background, please specify below:
 | **Asian / Asian British*** Indian
* Pakistani
* Bangladeshi
* Chinese
* Any other Asian background, please specify below:
 | **Black / African / Caribbean / Black British*** African
* Caribbean
* Any other Black / African / Caribbean background, please specify below:
 |
| **Other ethnic group*** Arab
 |