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| **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?* | | | | | | | | | ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **ARE YOU ON ANY MEDICATION?**  YES □ / NO □  *If “YES”, please list and give full details below* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |