To enable us to provide you with appropriate healthcare, please complete the following questionnaire.

Drs Watson, Charleson, Collie, Turner, Alderson & Sekulin

Name ______________________ Date of Birth ______________________

Address ______________________ Nationality ______________________

______________________ Marital Status ______________________

Tel. No.: Home __________ Office __________ Previous Surname ______________________

Email: ______________________ No of children - names & ages ______________________

Mobile No.: ______________________ ______________________

Emergency Contact Name: ______________________ ______________________

Emergency Contact Tel No: ______________________ Occupation: ______________________

We may contact you by text if we have been unable to make contact with you by telephone. You may opt out of this method of communication if you wish to do so - **OPT IN/OPT OUT (please indicate below):**

I am happy for the Practice to send me text messages, when deemed appropriate: **YES / NO**

Signature ______________________ Date: ______________________

Which ethnic group do you belong to? – You are not obliged to complete this section. Please tick as appropriate

☐ White ☐ Chinese ☐ Indian ☐ Bangladeshi ☐ Pakistani ☐ Black-African ☐ Black-Caribbean

☐ Other – please state ………………………………………………… ☐ I do not wish to give this information

Do you require an Interpreter? **YES / NO** Please state language ………………………………………………

Do you wish to nominate a preferred Doctor within the Practice? If so, please tick the Doctor of your choice below.

Dr D P B Watson ☐ **Dr F Charleson** ☐ **Dr W M Collie** ☐ **Dr G Turner** ☐ **Dr P Alderson** ☐ **Dr J Sekulin** ☐

It may not always be possible to see your preferred Doctor. You must be prepared to see other Doctors in the Practice.

Have you **ever** smoked cigarettes or tobacco? **YES NO** (Please circle)

If you have answered '**YES**' to the above question, please answer **<u>either</u>** a) or b) below:
If you have answered **'NO'**, please go to the next section.

a) How many cigarettes do you smoke in a day? __________ (Please write in number)

Do you wish to give up smoking? **YES NO** (Please circle)

Have you ever been given advice on how to give up smoking, e.g. advice leaflets or counselling? **YES NO**

b) Have you stopped smoking? **YES NO** __________ (Enter date stopped)

How many cigarettes did you smoke in a day?

How many units of alcohol to you estimate you consume in one week? __________ Units (Please write number)

1 unit of alcohol = 1 measure of spirits (whisky, gin, vodka, brandy)
or 1 small glass of wine or ½ pint of beer or lager

If you do not drink any alcohol, please write in '0'.

Have you ever been advised to stop drinking or to reduce the amount of alcohol you drink? **YES NO**

Please provide details of the following:

Height ______________________ Weight ______________________

Last Blood pressure recording (if known) Please state date ______________________

CARER/NEXT OF KIN – please provide details:

Name ______________________ Relationship ____________

Address ______________________

Contact Telephone Number ______________________

Is this a Carer **or** Next of Kin? (please circle) **CARER** **NEXT OF KIN**

Are **you** a Carer? **YES/NO** If **Yes** a) Relationship of person you look after ____________

b) Do you require Carer's Needs Assessment **YES/NO**

Do you have a Power of Attorney/Advanced Directive. If so, please provide a copy to the Practice.

Do you have a family history (Mother, Father, Brother, Sister) of:

	(Please circle)		Elaborate (Mother, Father, etc, giving age when diagnosed)
Heart Disease	**YES**	**NO**	
Stroke	**YES**	**NO**	
Diabetes	**YES**	**NO**	

YOUR OWN MEDICAL DETAILS:

Do you personally suffer from:	**(Please circle)**		**Elaborate**
Allergies	**YES**	**NO**	
Asthma/COPD/Respiratory	**YES**	**NO**	
Diabetes	**YES**	**NO**	
Heart Disease/Angina	**YES**	**NO**	
Raised Blood Pressure	**YES**	**NO**	
Epilepsy	**YES**	**NO**	
Stroke	**YES**	**NO**	
Under/Overactive Thyroid	**YES**	**NO**	
Cancer	**YES**	**NO**	
Mental Health problems, e.g. depression	**YES**	**NO**	
Have you ever injected drugs?	**YES**	**NO**	
Any other medical conditions/physical disability	**YES**	**NO**	

Previous medical history: Operations, hospital admissions, major illnesses. (Please give dates) ______________________

List any medication you are currently taking: ______________________

FOR WOMEN ONLY

Date and result of last smear ______________________

Are you currently taking the oral contraceptive pill? ______________________

GP PLAN ______________________