STOCK SURGERY

NEW PATIENT HEALTH CHECK MEDICAL HISTORY FORM

A copy of this form should be completed for **each** member of the family

1. PERSONAL DETAILS:

Title: Mr Mrs Miss Ms Other .....

Surname: ..... Date of Birth: ...../ ...../.....

Forenames: .....

Full Address: .....

..... Post Code: .....

Home 'Phone No:..... Mobile No: .....

To enhance the patients experience in ways that the practice communicates with its patients we have a Text Messaging Service i.e. appointment reminders, health promotion. **It is your responsibility to advise us if you change your mobile telephone number.**
Please tick if you do not wish to receive SMS messages from Stock Surgery ☐

Daytime/Work Contact No: ..... Occupation .....

Place of Birth: ..... (If London, Please Specify Actual Area)

Name & Address of previous doctor .....

Please state your Ethnic Origin .....

Next of Kin Name ..... Tel No .....

2. SMOKING: (Please Circle Relevant Answers)

Do You Smoke? Yes Never Ex - Smoker

If Yes, How Many per day? ..... If Ex-Smoker date stopped: .....

3. EXERCISE:

Daily Weekly Occasional None Type of Exercise: .....

4. WEIGHT: ..... HEIGHT: .....

5. ALLERGIES: Please give details of any allergies (e.g. medicines, eggs, nuts, vaccines or chickens)

Cause (e.g. drug name)	**Nature of reaction** (e.g. rash, lip swelling)

7. WOMEN ONLY QUESTIONS:

Do you use contraception? : YES / NO If so, which type: Pill Condom Coil Other

Are you currently pregnant? : YES / NO If yes, expected date of delivery: .....

Have you had a Cervical Smear?: YES / NO If yes, date of last smear: .....

Result of last smear: .....

FOR OFFICE USE ONLY	Date and Initials
Proof of address Documents seen: 1. 2.	

8. PRESENT MEDICATION: (Please list all medicines, pills, inhalers, etc)

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Please make an appointment to see the doctor if you use medication regularly

9. MEDICAL HISTORY: Do you have or ever had any of the following? Please tick Yes or No and give dates first suffered & details where appropriate.

CONDITION	Y	N	DATE	Details
Asthma				
Chronic Bronchitis/Emphysema				
Stomach or bowel trouble				
Cancer				
Diabetes				
Epilepsy / Fits				
High Blood Pressure				
Thyroid Trouble				
Stroke				
Mental Health Problems				
Heart Attack				
Angina				
Kidney Disease				
Other (give details):				

10. Family History

Has any of your close family (mother, father, sister/brother) had serious illness under the age of 60?

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11. IMMUNISATIONS:

TYPE	DATE	TYPE	DATE	TYPE	DATE
Tetanus		Rubella		Typhoid	
Diptheria		Polio		Hepatitis A	
Measles		Whooping Cough		Hepatitis B	
Mumps		TB		Other:	

12. OTHER INFORMATION: Please write below details of any other information you feel should be included in your medical records, for example serious accidents or operations (continue on separate sheet if necessary)

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Signed..... Date .....