STOCK SURGERY

NEW PATIENT HEALTH CHECK MEDICAL HISTORY FORM

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

PERSONAL DETAILS:

Title: Mr Mrs Miss Ms Other ....

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

Forenames: ....

Full Address: ....

.... Post Code: ....

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

Email address ....

To enhance the patients experience in ways that the practice communicates with its patients we have a text messaging service i.e. appointment reminders. ***It is your responsibility to advise us if you change your mobile number you can opt out at any time by informing the practice***

CONSENT TO RECEIVE SMS and Emails **YES / NO** delete as appropriate

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

Place of Birth: .... (If London, Specify Actual area

Name & Address of previous doctor ....

Please state your Ethnic Origin ....

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

ALLOCATED GP: Please be aware that you will be allocated a named GP within the Practice who will be responsible for your overall care; however you can still choose to see any GP at the Practice.

SMOKING: **(Please Circle Relevant Answers)**

Do You Smoke? Yes Never Ex - Smoker

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

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

WEIGHT: .... **HEIGHT:** ....

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

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

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: ....

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

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

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):				

Family History

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

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IMMUNISATIONS:

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

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 ....

Please note by signing this form you are consenting to receiving texts and emails from the practice.