Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_ Forename \_\_\_\_\_\_\_\_\_\_\_\_ Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Handling Personal Information - In order to be your healthcare provider we require to process your personal information - Please tick to accept

**How would you like us to contact you?**

 Mobile phone, including text messaging (providing number kept up to date), which ensures confidentiality.

 Home telephone – if I’m not available leave a message to contact.

 Letter only – I accept that this may delay information reaching me.

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnic Origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter required - Yes/No Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Contact Number/s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a carer? Yes/No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Carers Contact Number/s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a carer? Yes/No Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous GP details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone have power of attorney for you? Yes/No (if yes provide details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a DNACPR (not for pulmonary resuscitation) in place? Yes/No

**Lifestyle**

Do You Smoke? Yes/No If Yes, How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ex-Smoker Yes/No When did you stop? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes/No If Yes, how many units or glasses per week \_\_\_\_\_\_

Height if known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever suffered any of the following and if so at what age?

Heart Attack Angina Stroke Age/when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you Diabetic Yes/No If Yes is it controlled by Insulin Oral medication Diet

Do you suffer from any allergies? Yes/No - Provide details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only – Have you had a smear test in past 3 years? Yes/No

**Current Medication – we will confirm with your previous practice**

**Please provide your preferred chemist for uplift \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Name of Medication | Strength | When Taken |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Family History**

Have any of your relations suffered from any of the following aged under 65

Heart disease, Stroke, Diabetes, Asthma or Cancer.

If Yes – please tell us who what and at what age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_