

THE St JAMES PRACTICE

Welcome to our Practice. We hope that you will be happy with the care we provide for you. Our aim is to provide you with advice on many health issues and hopefully to keep you in good health.

Please complete as many of the following questions as you can. This information is COMPLETELY CONFIDENTIAL and will help us to provide you with the appropriate medical care for your needs.

DATE OF NEW PATIENT MEDICAL CHECK (where appropriate) _____
(Please bring a sample of urine in a clean container when you attend).

TITLE: (Mr/Mrs/Ms/Miss) _____

GENDER: MALE / FEMALE (please circle)

MARITAL STATUS: (please tick appropriate box)
SINGLE MARRIED WIDOWED
LIVING TOGETHER
SEPARATED DIVORCED

DATE OF BIRTH: _____

SURNAME _____

FORENAMES _____

ADDRESS _____

POST CODE: _____

TELEPHONE NUMBERS:

HOME: _____

MOBILE: _____

WORK: _____

OCCUPATION: _____

IF A CHILD, NAME OF SCHOOL ATTENDED:

(Please bring or send a copy of immunisation records to the surgery)

NAME OF NEXT OF KIN:

(please state relationship to you – wife, husband, partner, child, mother, father, foster parent, sister, brother, grandparent, friend, neighbour or other)

TELEPHONE NUMBER OF NEXT OF KIN:

NAME & ADDRESS of your PREVIOUS DOCTOR:

Are you a Carer? (Do you look after a relative or friend who is sick, disabled, elderly, who has mental health problems or for any other reason) YES NO

Do you have a carer yourself? YES NO

Do you have a disability / any special requirements that we need to take into account? YES NO

IF YES please give details _____

Religion (please tick): None Christian
Buddhist Hindu Jewish
Muslim Sikh Other

If OTHER please state: _____

What is your country of origin?: _____

Date of entry into UK (if not born here)? _____

What is your main spoken language(s)? _____

Do you need an interpreter? YES NO

Are you a refugee or an asylum seeker? YES NO

Which ethnic group do you feel you belong to? (please circle)

White:
White British
Irish
Other White (please specify)

Mixed:
White & Black Caribbean
White & Black African
White & Asian
Other Mixed (please specify)

Asian / British Asian:
Indian
Pakistani
Bangladeshi
Other Asian (please specify)

Black or Black British:
Caribbean
African
Other Black (please specify)

Other Ethnic Categories:
Chinese
Any other (please specify)

Not Stated: _____

FAMILY HISTORY: Do **YOU** or any of **YOUR RELATIVES** suffer from the following conditions?

Please ✓ appropriate boxes below

CONDITION	FAMILY MEMBER (please specify relationship)	YOU (Date)
Heart Attack		
Angina		
Stroke / TIA / Brain Haemorrhage		
Hypertension (<i>high blood pressure</i>)		
Diabetes Type 1 or Type 2		
Epilepsy		
Asthma		
COPD		
Hypothyroidism		
Kidney Disease		
Depression		
Dementia		
Mental Health Problems		
Obesity		
Cancer (<i>please specify</i>)		
Any other Diseases		

YOUR PAST MEDICAL HISTORY (*Please list any serious illness, operations or accidents with dates*)

DATE	TYPE OF OPERATION, ILLNESS, ACCIDENT or CONDITION

CURRENT MEDICATIONS (*Please include any medicines you regularly purchase from the Chemist or other retail outlet*)

NAME OF MEDICATION	<i>On Prescription</i>	<i>Purchased from Chemist / Shop</i>

KNOWN ALLERGIES (*Please list any allergic reactions you may have to drugs / medicines or any other substances.*)

TYPE OF ALLERGY	TYPE OF REACTION i.e. <i>rash / swelling etc</i>

SMOKING STATUS:

<i>Do you currently smoke?</i>	(Please tick the appropriate box)	
	YES	NO
<i>Do you roll your own cigarettes?</i>	YES	NO
<i>If YES, how many per day OR how many ounces of tobacco?</i>	___ per day	___ ozs
<i>Are you interested in trying to stop and being referred to the Smoking Cessation Clinic?</i>	YES	NO
<i>Are you an ex-smoker?</i>	YES	NO
<i>If YES, when did you stop?</i>		

ALCOHOL:

<i>How many units of alcohol do you consume in one week?</i> One unit = 1 Glass of Wine or Half pint or Single measure of spirit	(Please enter number of units)	
	None	
	Pints	
	Shorts	
	Wine	

EXERCISE:

<i>Do you take any form of exercise?</i>	(Please tick the appropriate box)	
	YES	NO
<i>Do you avoid exercise?</i>	YES	NO
<i>Is exercise impossible for you?</i>	YES	NO
<i>What type of exercise do you take?</i> <i>e.g. walking, swimming, gym, Aerobics etc</i>		
<i>How many times a week do you take exercise?</i>		
WEIGHT:	HEIGHT:	

DIET:

<i>Would you describe your diet as healthy and well balanced?</i>	(Please tick the appropriate box)	
	YES	NO
<i>Have you any special dietary requirements?</i>	YES	NO
<i>If YES please specify:</i>		

VACCINATIONS: *When did you last have the following vaccinations?*

TYPE OF VACCINATION	DATE
Tetanus	
Typhoid	
Polio	
Hepatitis A	
Hepatitis B	
MMR	
BCG	
Meningitis	
Influenza <i>(only if you are over 65 years of age or in an 'At Risk' group i.e. CHD; Stroke; Diabetic; COPD or Asthmatic)</i>	
Pneumovax <i>(should be given if you are 65 years of age and over OR in an 'At Risk' group i.e. CHD; Stroke; Diabetic; COPD; Asthmatic etc)</i>	

WOMEN ONLY:

Are your periods regular? **YES** **NO**

What was the first day of your last period? _____

Are you pregnant or could you possibly be pregnant? _____

Please state what method of contraception you use _____

If using Depo Provera, when is your next injection due? _____

When and where did you last have a Cervical Smear Test? _____
(If you have a copy of the result, please bring it to the surgery when you attend for your Health Check)

Have you had any previous abnormal smear results? **YES** **NO**

Number of Births: _____ Number of Miscarriages: _____ Number of Terminations: _____

Have you had a Hysterectomy? **YES** **NO**

If **YES** please state date and name of Hospital: _____

Do you take HRT? **YES** **NO**

IMPORTANT NOTE:

Contraceptive and HRT pills are not given as repeat prescription items without first having a check up with our Practice Nurse. At that appointment a six month supply will normally be prescribed.

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO TELL US THAT WILL HELP US TO PROVIDE YOU WITH THE APPROPRIATE MEDICAL CARE FOR YOUR NEEDS?

Patient's Signature: _____ **DATE:** _____

TO BE COMPLETED BY THE PRACTICE NURSE AT YOUR HEALTH CHECK APPOINTMENT:

DATE OF HEALTH CHECK:		YES	NO
HEIGHT		Dietary advice given	
WEIGHT		Exercise advice given	
BMI		Smoking advice given	
WAIST CIRCUMFERENCE		Smoking referral made	
URINE		Alcohol advice given	
BP		Contraceptive advice given	
PF (Asthmatics)		BCG Scar seen	
BM (Diabetics)			
NEXT SMEAR DUE DATE:			