The New Surgery

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www.thenewsurgery-brentwood.co.uk

1. **Personal Details:**

First Name			
Surname			
Former Surname			
Address	**Post code:**		
Date of birth			
Mobile number	**Text message consent: Y N**		
Home contact number			
Email address			
Occupation			
Next of Kin	**Name:**	**Contact No:**	**Relationship:**

2. **ETHNIC GROUP (please tick):**

White ☐ Black or Black British ☐ Asian or Asian British ☐ Mixed ☐ Chinese ☐
Other Ethnic group: _____

Male or Female **(please circle)** **Height (cm):** _____ **Weight (kg):** _____

3. **Do you have a carer?** Yes ☐ No ☐

Name of carer: _____ Contact number: _____

Are you the main Carer for an elderly or disabled person? Yes ☐ No ☐

4. **SMOKING:**

Do you smoke tobacco? Yes ☐ No ☐

If yes, Cigarettes ☐ Cigars ☐ Roll-ups ☐ Pipe ☐ Other ☐ please specify _____

How many each day? _____ How many years have you smoked? _____

Do you wish to stop smoking? Yes ☐ No ☐

Are you an Ex-Smoker? Yes ☐ No ☐
How many per day? _____ How many years? _____ When did you stop? _____

THE PRACTICE OFFERS A QUIT SMOKING PROGRAMME – PLEASE ASK IN THE TREATMENT ROOM FOR DETAILS TO MAKE AN APPOINTMENT

PTO

5. **BLOOD PRESSURE READING ……. / …….** Please use the self-checking machine in the treatment room and hand the slip to the reception staff with this form or when you next attend surgery.

6. NHS England has introduced the Summary Care Record which will be used in Emergency Care settings. The record will contain information about any medicines you are taking and any allergies that you suffer from. Please advise if you are happy to opt in to this programme. Any healthcare staff needing to access this information will ask your permission first.

   Yes I agree ☐ No I disagree ☐

7. **ALLERGIES (please specify):** _____

8. **EXERCISE HABIT:**

None ☐ Light ☐ Moderate ☐ Heavy ☐ Regular ☐ Please specify: _____

9. **ALCOHOL CONSUMPTION:** _____ **(Please complete the attached form)**

10. **ILLNESSES – do you suffer from (please tick)**

Diabetes ☐ Type 1 or type 2 **(please circle)** Epilepsy ☐ Asthma ☐ COPD ☐ Hypertension ☐

Other ☐ please state _____

Do you have or have you had:

Cancer ☐ Please specify _____ Heart problems ☐ please specify _____

Stroke ☐ Glaucoma ☐ Tuberculosis ☐ Any other long term/serious illness: _____

Have any other members of your family suffered from any of the illnesses listed above?
If so, please enter the relationship and the illness (**if Diabetes, please list whether Type 1 or Type 2**):

_____

11. **CURRENT/REPEAT MEDICATION – Please provide a copy of your repeat prescription from your previous GP if possible.** Please state below including dose and frequency if known:

_____

12. **FEMALES ONLY:**
    Type of contraception used: Barrier (condoms) / Oral contraceptive pill / Implant / Coil / Injection
    Are you currently pregnant? YES / NO / Unsure
    Date of last cervical smear: _____
    Have you ever had an abnormal smear result? YES / NO Details: _____ Date: _____
    Number of pregnancies (please include any miscarriages or terminations) _____

13. **Date of completing this questionnaire** _____ /_____ /_____