QUANTOCK VALE SURGERY

New Patient Details Form **Page 1**

All information provided will remain **confidential.**

Please complete this form and bring to the Surgery where you can make an appointment for a Health Check.

Personal Details:

Title (Mrs Mrs etc): Forename: Surname:

Date of birth: Telephone: Mobile:

Preferred Method of Contact please tick Mobile ☐ Home ☐ Email ☐

Address:

Email Address:

Emergency Contact Details:

Name: Telephone: Mobile:

Relationship:

Lifestyle:

Height: Weight:

Have you ever smoked? Y or N Do you still smoke? Y or N How many/much per day?

Do/did you smoke? Pipe / Cigarettes/ Cigars

How many units of alcohol do you drink in an average week? (1 Unit = $^{1}/_{2}$ pint of beer or 1 spirit measure)

Immunisation: What have you been immunised against? Please give dates:

Tetanus: / / Polio: / / Rubella: / / Other

Allergies: Are you allergic to any medication? If so please state what it is and what your reaction is:

Allergic to: Reaction:

Are you allergic to anything else, e.g. food items or insect stings? Please give details:

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PAST ILLNESS AND OPERATIONS: Please list (in order) all serious illnesses, operations, hospital admissions, accidents and permanent disabilities:

Event	Date started	Date ended

Family Illness: For any of the illnesses/conditions that your relatives may have (had) please state which relative ie Mother, Brother etc:

High blood pressure		Stroke		Eczema		Asthma	
Heart attack (under 60)		Diabetes		Other			

Medication: please list below all the medication you take regularly including those that you have bought over the counter. Please give the tablet strength and state how often you take it.

Medication	Prescribed?	Strength	How often
	Y or N		
	Y or N		
	Y or N		
	Y or N		
	Y or N		
	Y or N		
	Y or N		
	Y or N		

Where would you like you prescriptions to be dispensed?

The surgery has an attached pharmacy/dispensary. Are you happy for your prescriptions to be sent here:

Yes ☐

No ☐ (please tell us where you would like your prescriptions sent.....)

For Women:

Have you ever had a cervical smear? Y or N If Yes …… When: ---- / ---- / ----

Where was it done e.g. GP Surgery Result: Normal/Abnormal/Don't know

Have you had a hysterectomy? Y or N Date: ---- / ----/ ---- Reason:

Contraception: if you would like any advice or need further contraception please make an appointment with our Practice Nurse.

Please provide all relevant information, if you need more space continue on separate sheet

Carer Details

If you are a Carer for a dependent adult, please tell us who you care for:

Name	Address	Telephone No	Relationship

Ethnic Status
The Department of Health uses this information to identify any particular health needs or inequalities of health provision on the basis of ethnicity.

How would you describe your ethnic group?

British or mixed British: Yes ☐

Other: Yes ☐ Please specify

I would prefer not to say Yes ☐

If your first language is **NOT** English, please state what your first language is:

Additional Information

Please use this space and overleaf to add any further information.