# Summerhill Surgery

We would be very grateful if you could take time to complete this form. Any information given will be treated confidentially. If you have any queries about completing this form, please ask a member of staff. The information requested is to ensure we are able to provide the best level of care and to meet your health care needs appropriately. Please hand in the completed form to a member of staff. ***THANK YOU***

**Personal Details**

Forename…………………………….....
Surname……………………………….
Middle name(s)……………………….
Date of Birth……………/……/……..
House/Flat Name……………………...
No. and Street………………………….
Town…………………………………..
Postcode……………………………….
Home Telephone No…………………
Mobile Telephone No………………..
Email Address......................................

**Next of Kin**

Next of Kin……………………………
Relationship..........................................
House/Flat Name……………………..
No. and Street…………………………
Village………………………………...
Town…………………………………..
Postcode………………………………
Telephone No…………………………

Are you happy for the practice to contact you by text message (SMS) for either health promotion or to confirm your appointments? Yes / No

Have you been registered at this practice before? Yes / No
If so, how long ago? ……………………………………………

What was your address?……………………………………….

Which of the following best describes your ethnicity?

| A. White | B. Mixed | C. Asian or Asian British | D. Black or Black British | E. Any Other |
|---|---|---|---|---|
| British | White & Bl Caribbean | Indian | Caribbean | Chinese |
| Irish | White & Bl African | Pakistani | African | Yemeni |
| Other | White & Asian | Bangladeshi | Black Other | Travellers |
| | Any Other Mixed | Asian (other) | | Any Other |

**What religion do you practice?**

Buddhist    Christian    Hindu    Jewish    Muslim    Sikh

Any other (Please specify) ………………………    None    Do not wish to state

**What is your preferred language? (Written or spoken)**

Arabic    Bengali    Chinese / Cantonese    English    Gujarati    Hindi
Panjabi    Urdu    Other (Please specify) …………………………………..

## Medical Conditions

Do you have any of the following?

| | Yes | No |
|---|---|---|
| Heart Disease | | |
| Diabetes | | |
| Asthma | | |
| Epilepsy | | |
| Hypothyroidism | | |
| COPD | | |
| Rheumatoid Arthritis | | |

Are you allergic to any substances or foods? Yes / No

If yes, please give details:
………………………………………………………………………………………………………

Do you have or are you a carer? …………………………………………………………...

Are you registered disabled or have any significant disability?……………………………..……

Do you have any communication needs? ……………………………………………………

Do you need a format other than standard print?……………………………………………

Please give details of any major surgery…………………………………………………..

Any other conditions?………………………………………….......................................

## Medication

**Please give details of any medication that you regularly take, including the pill. Please also include the dose you require.**

1……………………………………….
2……………………………………….
3……………………………………….
4……………………………………….
5……………………………………….
6……………………………………….
7……………………………………….
8……………………………………….

## Immunisations

| | Yes | No | Date |
|---|---|---|---|
| MMR | | | ……/……/…... |
| Measles | | | ……/……/…... |
| Mumps | | | ……/……/…... |
| Rubella | | | ……/……/…... |
| HPV | | | ……/……/…... |
| Influenza | | | ……/……/…... |
| Pneumonia | | | ……/……/…... |

Other (please specify) ……………………………………………………….

Is there any of the following in your family *(father, mother, brother, sister)* before age of 65?

Heart Disease (heart attacks, angina) Yes / No Which family member? …………………………

Stroke? Yes / No Which family member? …………………………

Cancer? Yes / No Which family member? …………………………

**Smoking**

Do you smoke? Yes No If so how many…………..per day.

Have you previously smoked? Yes No

**Alcohol**

**For the following questions please <u>circle</u> the answer which best applies**
**1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits**

- Men: How often do you have EIGHT or more drinks on one occasion?
  Women: How often do you have SIX or more drinks on one occasion?

  Never Less than monthly Monthly Weekly Daily or Almost Daily

- How often during the last year have you been unable to remember what happened the night before because you had been drinking?

  Never Less than monthly Monthly Weekly Daily or Almost Daily

- How often during the last year have you failed to do what was normally expected of you because of drinking?

  Never Less than monthly Monthly Weekly Daily or Almost Daily

- In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

  No Yes on one occasion Yes on more than one occasion

**Exercise**

Do you take regular exercise? Yes / No

If Yes what kind of exercise do you perform?
Not at all Light Moderate Heavy Competitive

What is your weight …………… Height ………… Waist measurement ……………..