NEW ADULT PATIENT (16+YEARS)

PLEASE COMPLETE THIS FORM CLEARLY IN CAPITAL LETTERS USING BLACK INK

PERSONAL DETAILS

TITLE: Mr / Mrs / Miss / Ms / Other .....

SEX: Male / Female
SURNAME
PREVIOUS SURNAME
FORENAME(S)
DATE OF BIRTH
TOWN & COUNTRY OF BIRTH
ETHNIC ORIGIN

CONTACT DETAILS

NO & STREET
TOWN
COUNTY
POST CODE
HOME PHONE
WORK PHONE
MOBILE PHONE
HOME E-MAIL
EMERGENCY CONTACT NAME
EMERGENCY CONTACT'S PHONE
DO YOU LIVE IN A CARE / NURSING HOME? Y / N
ARE YOU A CARER? Y / N

PREVIOUS DETAILS

PREVIOUS ADDRESS
No & street
Town
County
Post Code

Were you registered with your previous GP at this address? Y / N

if No, what address does your previous GP have for you?
.....
.....

PREVIOUS GP
GP's Name
Practice Name
Practice Address
Practice Telephone

THE MOUNTWOOD SURGERY

Welcome to our our surgery

As part of our commitment towards improving health we expect:

- *all qualifying women (25 to 65 years) to be up-to-date with cervical screening.*
- *all patients with chronic medical conditions (e.g. heart disease, diabetes, asthma, epilepsy, chronic lung disease, etc) should make an. appointment with our nurse as soon as possible.*
- *If you are on repeat medication please attach a copy of your medication list and bring the list (or all your medicines) along on your first appointment*

YOUR GENERAL HEALTH

Height: Weight:
Exercise level: none / light /moderate / vigorous
Special diet? Y / N If yes .....
Smoker? No Never / Ex-smoker stopped .....
Smoker? Yes Smoke...../day since .....

Alcohol intake: .....Units/wk
(1 unit=1/2 beer, small glass wine, 1 single spirit)

If you travel abroad regularly, are you up-to-date with your travel vaccinations? Y / N

PAST & PRESENT MEDICAL HISTORY

Include hospital admissions, operations, accidents, and chronic or serious illnesses

Condition	*Month / Year*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

ALLERGIES

List any reactions to drugs, plasters, foods, etc

What triggers it? *Description of reaction*

YOUR MEDICATION

List your regular medicines including any over the counter or complimentary medicines

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

YOUR PRESENT HEALTH STATUS

Prior to joining us have you been attending any:

nurse clinic at your previous GP's? Y / N

If so, what for.....

If so, what for.....

hospital clinics? Y / N

If so, what for.....

If so, what for.....

If so, what for.....

any other health professional ? Y / N

If so, what for.....

Do you suffer from any of the the following?

Raised blood Pressure	Y / N
Previous Heart Attack or angina	Y / N
Stroke or TIA	Y / N
Diabetes	Y / N
Chronic kidney condition	Y / N
Asthma or Chronic Lung condition	Y / N
Cancer	Y / N
Mental Health Problems	Y / N
Immune suppression conditions or drugs	Y / N
Cancer	Y / N

FOR FEMALES ONLY

Have you had a cervical smear Y / N

If Yes, when?.....

where? previous GP, other.....

Smear result *normal/abnormal/not sure*

Have you contraception needs? Y / N

If Yes, current method.....

Have you had a hysterectomy? Y / N

If Yes, reason?.....

Date of operation: .....

THANK YOU FOR COMPLETING THIS FORM

For Official Use Only

Please send appointment for the following clinic(s)

1.

2.

3.

Notes:

☐ *Data transferred to EMIS*

☐ *For scanning into records*