THE BRUNSTON & LYDBROOK PRACTIC	<b>E</b> Date		
Medical Information Form (if you need help completing this form or more paper please ask at reception)			
We would like to take this opportunity to welcome you to the Practice. We would be grateful if you could take the time to fill in the following health details. This information will help us until we are in receipt of your medical records from your last registered doctor and will enable us to provide you with the best possible healthcare. Please complete both sides of this form, for each member of your family, and then book a New Patient Check appointment at reception. Thank you.			
ABOUT YOU			
TITLE (PLEASE CIRCLE) Mr Mrs Ms Miss Master	Doctor Rev Other (please state)		
FULL NAME	" ,		
TELEPHONE NUMBERS we can use to contact you	J.		
Home:	It's really important these telephone		
Work:	numbers are kept up to date, please		
Mobile:	remember to tell us if you change them!		
DATE OF BIRTH			
What is your country of birth?			
What is your main spoken language?			
Do you require an interpreter? (please circle)	YES NO		
YOUR OCCUPATION / PREVIOUS OCCUPATION			
TOOK OCCOLATION TIRE VIOUS OCCOLATION	II KETIKED.		
ARE YOU REGISTERED DISABLED (please circle)	YES NO		
DO YOU HAVE OR ARE YOU ARE CARER? Please complete the enclosed "Carers Form"			
and hand back to reception.	'		
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GENERAL HEALTH QUESTIONS			
HEIGHT WEIGHT			
EXERCISE HABITS – aerobic exercise (please circle	e)		

HEIGHT	WEIGH	HT	
EXERCISE HABITS – aerobic exercise (please circle)			
0 times/week 1 time/week	k 2 times/week	3+ times/week	Inadequate exercise

ALCOHOL if aged over 16 – Please answer these 3 questions by circling the answer					
Question	0	1	2	3	4
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day?  If never, please ignore	1 – 2	3 – 4	5 – 6	7 – 9	10+
How often do you have <b>6</b> or more standard drinks on one occasion?  If never, please ignore	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

 SMOKING (please circle)
 SMOKING CESSATION ADVICE IS AVAILABLE HERE FREE!

 Smoker
 Ex Smoker

 Cigarettes/Cigars/Pipe
 Never smoked
 Date stopped

 N° per day......
 Previous N° per day ......

## SCHOOL INFORMATION (school age children only)

Name of school currently attending:

## ABOUT YOUR MEDICAL HISTORY

SERIOUS OR CHRONIC ILLNESS please circle if YOU HAVE/HAD any of the following					
Blindness/Glaucoma	Stroke	High/Low Blood Pressure			
Diabetes	Heart Attack	Epilepsy			
Asthma/Eczema/Hayfever	Depression	Cancers (Bowel/Breast/Lung/Other)			
OTHER SERIOUS/CHRONIC ILLNESS OR OPERATIONS  please also state where and when					
ALLERGIES – Do you have any allergies? If so, what are you allergic to?					

## **ABOUT YOUR MEDICINES**

If you have any regular medications please supply us with a copy of your repeat medication list from you last prescription.

## ABOUT YOUR FAMILY

SERIOUS OR CHRONIC ILLNESS IN YOUR PARENTS/SIBLINGS OR CHILDREN please circle and state details including relationship and age.

Blindness/Glaucoma Stroke High/Low Blood Pressure

Diabetes Heart Attack Epilepsy

Asthma/Eczema/Hayfever Depression Cancers (Bowel/Breast/Lung/Other)

Sudden Death

FOR FEMALES ONLY		
If known:		
Date of last cervical smearar	nd last mammogram	
Contraception used (please state type and/or name)		
Where do you obtain your contraception supplies from? (please circle)		
GP Clinic	Local Family Planning Clinic	

If you need help completing this form or further paper please ask at reception.

THANK YOU FOR COMPLETING THIS FORM

May 2011