Heart Attack/Angina: …………………………………………………………………….

Asthma: ……………………………………………………………………………………….

High Cholesterol: ………………………………………………………………………….

Depression: ………………………………………………………………………………….

Any inherited condition: ………………………………………………………………

Any other serious illness/hospital stay/ operation:

………………………………………………………………………………………………………

……………………………………………………………………………………………………..

**Height**…………………………………… **Weight**……………………………………….

Has a close relative (parent, brother, sister, uncle, aunt) ever had any of the above? Please state who/what: …………………………………..

………………………………………………………………………………………………………

**Do you take any regular medication, including the contraceptive pill? YES/NO**

If yes please state what your treatment if for, and name and dose of drug if known: ………………………………………………………………………………………………………

……………………………………………………………………………………………………...

……………………………..

Or ask your pervious surgery for a print out of your medication.

**Do you have any allergies to medicines, pollen, dust, animals, or any foods?**

If yes please give details and state if you use an Epipen: ……………….

……………………………………………………………………………………………………….

**- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -**

**WOMEN ONLY:**

**Have you ever had a cervical smear test?**

**YES/NO If yes:**

* When was your last smear?……………...……………………
* Where? Circle one:

GP/Clinic/Hospital/Private Doctor

* Was it normal? YES/NO
* Was that your first smear? YES/NO
* Have you ever had an abnormal smear?

YES/NO If yes, please give details: ....................................

...........................................................................................

**Do you check your breast regularly? YES/NO**

**- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -**

**MEN ONLY**

**Do you check your testes regularly? YES/NO**

**Any patient over 40 will be asked to come in for a NHS Health Check.**

We may not receive your records for some time and it is really important that we know if you have had any illnesses, or are on treatment/ medication. If you are not sure of the answer on anything, just put **“Don’t Know”**

**Surname: ……………………………………………………………………………..**

**Forename(s): ………………………………………………………………………..**

**Preferred calling name: ………………………………………………………..**

**Date of birth: ………………………………………………………………………..**

**Mobile No: …………………………………………………………………………….**

**E-mail: …………………………………………………………………………………..**

**Occupation: …………………………………………………………………………..**

**Country of birth: ……………………………………………………………………**

**Main language:**

**………………………………………………………….**

**Interpreter required: YES/NO**

**Do you have any information/ communication needs? YES/NO**

**If yes, please advise RECEPTION now.**

**Are you a Carer? If without payment you are looking after a partner, friend or relative who depends on your support due to frailty, illness, disability, a mental health or substance misuse condition then you ARE a carer YES/NO**

**- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -**

**Are you currently in good health? YES/NO**

If no please give details: …………………………………………………………………………………………………

………………………………………………………………………………

**Do you take regular exercise? YES/NO**

**Do you have concerns you would like to discuss at the moment? YES/NO**

If yes please give details, or ask at reception to book an appointment: …………………………………………………………………………………………………

………………………………………………………………………………

**Please give details of any serious illnesses with approximate dates:**

Diabetes: …………………………………………………………………………………

Cancer (give type e.g. breast, lung etc.)…………………………………...

…………………………………………………………………………………………………

High Blood Pressure/Stroke: …………………………………………………...

The Roehampton Surgery

Registration Health Questionnaire- Adults over 16

**The**

**The Roehampton Surgery Patient Participation Group (TRSPPG)**

**When registering with the surgery you will automatically become a member of TRSPPG,** and agree that we add your e-mail address to the TRSPPG Virtual Patient group and/or pass your name and other contact details to the group. The aim of the group is to assist doctors and staff to provide, and patients to access, the best possible health care at The Roehampton Surgery. By becoming a member you will receive e-mail updates of any changes at the practice, invitations to any activities organised by the group, and the occasional request to complete online in-house surveys about services to patients.

**IF YOU DO NOT WISH TO BECOME A MEMBER OF TRSPPG PLEASE TICK THIS BOX □**

**ETHNIC GROUP**

The Department of Health requires us to record the ethnic group of all our patients, as government wants to make sure there is no discrimination against any ethnic group (Race Relations Amendment Act 2000). You do not have to tell us your ethnic group if you do not want to - just tick the “not stated” box.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| British |  | Caribbean |  | White & Black African |  |
| White British |  | African |  | White & Black Caribbean |  |
| Irish |  | Other black background |  | White & Asian |  |
| White Irish |  | Pakistani/ British Pakistani |  | Other Mixed Background |  |
| Other White |  | Bangladeshi |  | Chinese |  |
| British/ Mixed British |  | Indian / British Indian |  | Other Ethnic Group |  |
|  |  | Other Asian Background |  | Not Stated |  |

**Would you be interested in help in stopping smoking? YES/NO/not applicable**

**Alcohol**

**1 unit= 1 small glass of wine, a single measure of spirits, ½ pt. of beer. Using this as a guide, how many UNITS of alcohol do you drink per week?...............units**

* **How often do you have a drink that contains alcohol?**

Never monthly or less 2-4 times a month 2-3 times a week 4+ times a week

* **How many standard alcoholic drinks do you have on a typical day when you are drinking?**

1-2 drinks 3-4 drinks 5-6 drinks 7-8 drinks 10+drinks

* **How often do you have 6 or more drinks on one occasion?**

Never less than monthly monthly weekly almost daily/daily

* **How often during the last year have you failed to do what was normally expected of you because of drinking? (E.g. being unable to do something because of a hangover.)**

Never less than monthly monthly weekly almost daily

**Smoking**

**Do you smoke? YES/NO**

If yes, how many cigarettes a day on average? ..................

**Have you ever smoked? YES/NO If YES:**

* How much did you smoke? .................................cigarettes/pipe/cigar/roll ups per day
* When did you give up? ....................................................

The Roehampton Surgery

Registration Health Questionnaire- Adults over 16

The Roehampton Surgery

Registration Health Questionnaire- Adults over 16

**Please provide your next of kin details or someone that we can contact in an emergency:**

**Name:**

**Telephone number:**

**Address:**

**Relationship of person to you?**