Personal Information

It is important that we hold up to date information to ensure that you receive all relevant medical information & treatment.

I would be grateful if you could spend a couple of minutes completing the information sheets. **Please hand it in at the surgery when you attend your appointment.**

Thank you

Patient name ____

Date of birth ____

Address ____

____

____

____

Patient care text messaging

We will soon be offering our patients a new text messaging service for the purpose of health promotion and for appointment reminders. On average 1 week worth of appointments is lost every 12 weeks due to appointments not being kept. In order to participate in this service please complete the consent form below.

Mobile phone number __________________________________

Home number (if this accepts text messaging) __________________________________

I consent to the practice contacting me by text message.

I acknowledge that appointment reminders by text are an additional service and that these may not always be available. Responsibility for attending appointments or cancelling them still rests with me.

I can cancel the text message facility at any time.

At present the surgery does not have a facility to accept replies by text. Once this becomes available patients will be advised accordingly.

Text messages are generated using a secure facility; however, they are transmitted over a public network onto a personal telephone which may not be secure. The practice will therefore not transmit any information which would enable an individual patient to be identified. **The practice does not share mobile phone contact details with any external organisation.**

Patient name __________________________________

Signature __________________________________

Date __________________________________

Health data

Please tick one of the following boxes & insert a number where applicable.

I have never smoked cigarettes/pipe/cigars _______

I have stopped smoking _______ weeks/months/years ago

I smoke _______ cigarettes a day

I use a pipe and smoke ______ ounces of tobacco a week

I roll my own cigarettes and smoke ______ ounces of tobacco a week

I drink _________ units of alcohol per week

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Height ____________ft/inches or metres

Weight ____________stone/LB or Kilos

Waist circumference __________ inches or centimetres

Do you have a history of heart disease?	YES / NO
Under 60 years	YES / NO
Over 60 years	YES / NO
Do you have a family history of stroke?	YES / NO
Do you have a history of diabetes?	YES / NO
Do you have a family history of asthma?	YES / NO
Would you like weight management advice	YES / NO
Would you like advice on giving up smoking	YES / NO
Would you like to receive sexual health screening	YES / NO

Ethnic origin

This section is not compulsory but may help with your healthcare as some health problems are common in specific communities and knowing your origins may help with the early identification of some of these conditions.

WHITE

British	☐
Irish	☐
Any other white background	☐

MIXED

White & Black Caribbean	☐
White & Black African	☐
White & Asian	☐
Black / Asian	☐
Any other mixed background	☐

ASIAN or ASIAN BRITISH

Indian	☐
Pakistani	☐
Bangladeshi	☐
Any other Asian Background	☐

BLACK or BLACK BRITISH

Caribbean	☐
African	☐
Any other black background	☐

CHINESE or OTHER ETHNIC GROUP

Chinese	☐
Any other	☐
I do not wish to divulge	☐

What is your first language? ________________________________