PATIENT DETAILS

To help us to provide you with the best possible care we would be grateful if you would take the time to answer **All** the following questions.

|  |  |
| --- | --- |
| Surname: | Title: Mr/Mrs/Miss/Ms/Dr/Other |
| Forenames: | |
| Date of Birth: | Previous Surname: |
| Address: | |
| Post Code: | Home Phone: |
| Email: | |
| Mobile Phone: | Work Phone: |
| Do you consent to receive:  SMS notifications Yes No  E-mail notifications Yes No | |

**NEXT OF KIN**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Are they registered with us?** | | | **Y ☐ N ☐** | **Relationship to you?** |  | |
| **Their Full name** |  | | | | | |
| **Their Contact number** | |  | | | **Their DOB:** | / / |

**BLOOD PRESSURE**

**If you do not have access to a Blood Pressure machine there is a machine at the surgery in the waiting room.**

|  |  |  |
| --- | --- | --- |
| **Date taken** | **Pulse** | **Blood pressure** |
|  |  |  |

**WOMEN ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have?** | **YES** | **NO** | **Name of Coil** (e.g. Mirena) | **Date due for replacement** |
| A Coil |  |  |  |  |
| A Contraceptive Implant |  |  |  |  |

**LIFESTYLE INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Exercise:** Would you describe yourself as: (please tick) | | | |
| Very Active | Active | Lightly Active | Inactive |

|  |  |
| --- | --- |
| (For Office Use Only) EMIS NO: |  |
| ID seen by: | Photo ID ☐ Proof of residence seen ☐ |