**Welcome to the Belmont Health Centre**

Thank you for completing this questionnaire. All information you give is confidential and will be held on you medical records. Please can you:

Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS**

Provide a specimen of Urine

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Surname |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Forename |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Date of birth |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email address |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| We may occasionally communicate with you by SMS or email. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do NOT wish to be contacted by email or SMS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Who should we contact in an emergency?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone number | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Ethnicity**

What is your country of birth? What is your first language?

White British

Other White ethnic group

Black British

Black Caribbean

Black African

Black other

Other Black ethnic group

Indian

Pakistani

Bangladeshi

Chinese

Vietnamese

Other Asian ethnic group

I do not wish to state my ethnic group

Other ethnic group (please state):

**Religion**

No religion

Christian

Buddhist

Hindu

Jewish

Muslim

Sikh

Any other religion (please state

**Social Habits**

**Smoking**: please tick the box that applies to you

I am a SMOKER How many per day?

I am an EX-SMOKER When did you stop smoking?

I have NEVER SMOKED

**Alcohol:** 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 when you are drinking?

*One standard drink is: 1 single measure of spirits, 1 small glass of wine, half a pint of beer, lager or cider. A bottle of wine is 9 units*

1-2

3-4

5-6

7-9

10+

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

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

**Measurements**

**Height:** Feet/inches: Metres:

**Weight:** Stones: Kg:

**Waist:** Inches: Centimetres:

**Exercise:** Do you take exercise that lasts for at least 20 minutes per session?  Yes No

If yes, how many times a week?  1  2  3+

**Do you work?**

Employed Self-employed Unemployed Homemaker Student Retired

What is your current occupation?

**Carer/Housebound Information**

Do you have a Carer?  Name and contact no. of Carer:

Are you a Carer?  Name of person you care for:

Are you housebound?

**Family History**

Have any of your close family (parents/brother/sister) had any of these illnesses or conditions?

|  |  |  |
| --- | --- | --- |
|  |  | Details, for example Father, Mother, Sister |
|  | Raised Cholesterol |  |
|  | Stroke |  |
|  | Heart Disease before the age of 60 |  |
|  | Heart Disease after the age of 60 |  |
|  | Asthma |  |
|  | Cancer |  |
|  | Diabetes |  |

**Past Medical history:** Please list with dates and **significant** current or past illnesses, operations or allergies

|  |  |
| --- | --- |
| **Illness, Operation Or Allergy** | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |

**Women Only**

Are you pregnant? Yes No If yes, when is your baby due?

When was your last cervical smear examination? Result:

When was your last Breast screening X-ray (mammogram)? Result:

What type of contraception do you use, if any?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Oral contraception (the Pill) |  | Diaphragm |  | Contraception not needed |
|  | Condom (sheath) |  | Patch (transdermal) |  | No current contraception |
|  | Depot Injection |  | Ring (Nuvaring) |  | Other (please state) |
|  | Coil (IUD-Intrauterine) |  | Implant (Implanon/Nexplanon) |

**Drugs and Medications:** If you require any medication, you must make an appointment with a Doctor for this to be issued. Please bring your repeat medication slip or attach your last prescription.

**Thank you for your time and help in completing this questionnaire**

*Issuing of the registration documents does not guarantee registration with this Practice*

**For office use only**

**Proof of ID seen:**  Yes  No

Document Initials/Date

**Proof of address seen (e.g. Utility bill):**  Yes  No

(NPM)

Appointment Booked Date