**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