Welcome to Barnoldswick Medical Centre

Please complete the questionnaire to help us gather as much information as possible to help with your future care.

All information is STRICTLY CONFIDENTIAL. Please can we remind you that patient confidentiality is our priority. If you wish to allow relative/partners to be given any of your medical information, then we need to receive a signed consent form which will be held on your medical record.

PERSONAL INFORMATION **PLEASE WRITE IN BLOCK CAPITALS**

Gender: **M / F**

Mr / Mrs / Miss / Ms (circle status) Date of Birth: .....

First Name: ..... Surname: .....

Address: .....
.....
.....
Postcode: .....

Telephone Number
Home: ..... Mobile: .....
Please confirm you are happy for us to send you appointment reminders and other information relevant to your care by text message: **Yes / No**

Email Address: .....
Please confirm you are happy for us to send you relevant information by email: **Yes / No**

I would like to register for on-line appointments **YES / NO**

I would like to register for on-line prescriptions **YES / NO**

I would like to register for text messaging services **YES / NO**

Occupation: .....

Next of Kin: ..... Relationship to patient: .....
Telephone Number: .....

LANGUAGE

Is English your first language: **Yes / No**
If **No** please state first language:

COUNTRY OF ORIGIN .....

ETHNICITY .....

HEALTH

Your **Height**: Your **Weight:** Your **Blood Pressure:**

Do you / or have you ever smoked? **Smoker / Never Smoked / Ex-smoker – date of quitting:** .....

EXERCISE

Which of these best describes the kind of exercise you take?

Impossible / None / Light / Moderate / Strenuous / Competitive Athlete

How many times do you exercise each week? ..... *(please specify)*

FEMALE PATIENTS

Have you had a cervical smear? **Yes / No**
If **Yes**, Year: ..... Result: .....

Have you had a hysterectomy? **Yes / No**
If **Yes**, Year: ..... Result: .....

CARERS

Do you care for someone with a disability / illness? **Yes / No**

If you have disability / illness, do you have a carer? **Yes / No / Need one**

CURRENT TREATMENT/ILLNESSES

Long term lung disease	Yes / No	Irregular heart beat	Yes / No
Asthma	Yes / No	Diabetes	Yes / No
Heart Disease	Yes / No	Liver Disease	Yes / No
High blood pressure	Yes / No	Dementia	Yes / No
Depression	Yes / No	Mental Health issues	Yes / No
Other	Yes / No (please write below)		

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ALLERGIES

Have you ever had an allergic reaction? **Yes / No** e.g. medication, latex, insect stings
If **Yes**, please specify .....

DIET

Normal Diet / Diabetic / Vegetarian / Weight Reducing / Medical / Other
If **Other**, please specify .....

Are you under hospital treatment for any condition? **Yes / No**
If **Yes** give details .....

Are you on any regular medication? **Yes / No**
If **Yes** give details .....
.....
.....
Please include a copy of your last prescription if you have it. This will speed the process up and ensure accurate information.

ALCOHOL CONSUMPTION - Please circle your answers

How often do you drink that contains alcohol?
Never / Monthly or less / 2-4 times per month / 2-3 times per week / 4+times

How many standard alcoholic drinks do you have on a typical day when you are drinking?
1-2 / 3-4 / 5-6 / 7-8 / 9+

How often do you have 6 or more standard drinks on the one occasion?
Never / Less than monthly / Monthly / Weekly / Daily or almost daily

Patient Declaration

I understand that it is my responsibility to advise Barnoldswick Medical Centre, in writing, should any of my details change, ie mobile number, email address, home address. I understand that Barnoldswick Medical Centre will continue to use the numbers given above until advised by myself.

There may be occasions when the Practice needs to get in touch with you. It may be that the quickest form of contact is to phone you. Do you consent to us leaving a message with a third party or on your voice mail requesting that you make contact with us or sending you a text message to your mobile phone? (No medical information will be left or disclosed). **YES / NO**

Date: .....
Name: .....
Signature: .....