DR J O ARAYOMI

EASTWING DIPPLE MEDICAL CENTRE, WICKFORD AVENUE, PITSEA, ESSEX

NEW PATIENT APPLICATION/HEALTH FORM

Thank you for completing all sections of this form. Please bring your completed form with you with confirmation of your address (eg. Utility Bill) and proof of identity (Birth Certificate/Passport/Driving Licence)

When seeing the nurse for your New Patient Health Check please bring with you any medication that you are currently taking.
Thank You

FULL NAME ……

Title: ……. Male/Female: …….. Date and Place of Birth: ……

Marital Status: ……

Full Address (including Post Code): ……

……

Telephone Numbers: Landline: …… Mobile: ……

Previous GP: …….. NHS Number: ……

ETHNICITY: ……

LANGUAGE: ……..

MEDICAL HISTORY

Please answer the relevant questions as this will help the practice assist your health needs in the future

PAST MEDICAL HISTORY:

Have you had any of the following? – Please Tick

ASTHAMA [ ] DIABETES [ ] EPILEPSY [ ] MENTAL ILLNESS/DEPRESSION [ ]

SURGICAL OPERATIONS [ ] Please Specify ……

HEART PROBLEMS (Eg. Murmurs or Blood Pressure) [ ]

OTHER CONDITIONS: Please Specify ……

ARE YOU ALLERGIC TO ANY MEDICATION [ ] If so Please Specify …….

…….

ARE YOU TAKING ANY MEDICATIONS? [ ] If so Please List (Including any Hayfever Treatment) ……

……

IS THERE ANY FAMILY (Parents/Brothers/Sisters) HISTORY OF: Cancer, Diabetes or Stroke? Please Specify ……..

LIFESTYLE

Do you Smoke? YES/NO If no, have you ever smoked? YES/NO If yes, how many Cigarettes/Cigars/Tobacco do you smoke? Please Specify …….

DO YOU DRINK ALCOHOL? YES/NO If Yes Please Specify (per week)

Pints of Beer ……. Glasses of Wine …….. Bottles of Wine …….. Spirits ……..

DIET

Do you eat a varied diet? YES/NO (including meat, milk, vegetables & fruit)

EXERCISE

How many times a week do you regularly take exercise? ……

What type of exercise? …….

IMMUNISATIONS

Please give approximate dates of your last immunisations

Tetanus …….. Polio …….. Other (please specify) …….

Do you currently have any health worries? If so please specify …….

CARERS

Do you look after someone that is Frail, Disabled or Mentally Ill? YES/NO

If YES would you like to fill in a Carer Identification Referral form? YES/NO

FOR WOMEN ONLY

Have you had a Smear in the last five years? YES/NO

Date of last Smear (Month and Year if possible) ……

Result of last Smear: Normal/Need for Further Test/Not known

Breast Screening Status: Have you had a Breast Screen Examination or a Teaching in How to Examine you breast? YES/NO

Contraception: Please state if you are using any Contraception and what type – Pill/Sheath/Condom/Injection. Name of Pill is used ……

Would you like any Family Planning matter? YES/NO

SUMMARY CARE RECORD

The Summary Care Record (SCR) is a summary of a patient's **allergies & medication** only uploaded to Spine so that it can be accessed by any legitimate carer, regardless of the computer system they use. The circumstances when this is beneficial include when a patient is seen at a Hospital or Out of Hours unit or when a temporary resident is seen at a GP practice.

Would you like to consent to sharing your record in the way described above? YES/NO

RECORD SHARING

You can choose to permit or restrict access to the information entered into your record at each health care organisation that uses the same computer system as us.
Do you agree to give consent to our record sharing with these organisations? YES/NO
(Please note that this consent can be changed at any time)

Signed (Patient/Guardian) ……..

FOR SURGERY USE ONLY

Registered GP …….. Smoking Advice Given? YES/NO

Alcohol Advice Given? YES/NO

Height …….. Weight …… BloodPressure ……

Urine ……..