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CLIFF VILLAGES MEDICAL PRACTICE – PATIENT QUESTIONNAIRE

NAME (MR/ MRS/ MISS).....D.O.B.....
ADDRESS: .....
.....
.....
TELEPHONE: (HOME) ..... (MOBILE) .....
EMAIL.....
We are looking at sending appointment reminders and contact requests by text message. No confidential information, such as test results, will be sent this way. If you agree to us using this method of contact at some stage in the future, please indicate here: YES / NO
It is your responsibility to inform us of any change in your contact telephone numbers.
WHAT ETHNICITY ARE YOU? .....
PRESENT MEDICATION (INCLUDING CONTRACEPTIVE PILL)
.....
.....
.....
Please note: An appointment with a Doctor will be required before we are able to issue any medication. Please arrange an appointment at your earliest convenience.
ALLERGIES: .....
.....
ALCOHOL UNITS PER WEEK ..... CIGARETTES PER DAY .....
DO ANY FAMILY MEMBERS/CLOSE RELATIVES HAVE ANY OF THE FOLLOWING (PLEASE GIVE RELATION AND AGE OF ONSET)
Diabetes mellitus .....
High blood pressure .....
Heart disease/Angina/MI .....
Stroke .....
Cancer (Please state site) .....

IF YOU HAVE RECENTLY LEFT THE ARMED FORCES:
DATE OF ENLISTMENT ..... DATE OF DISCHARGE .....
IF YOU HAVE RECENTLY RETURNED FROM ABROAD AND ARE A DEPENDANT OF THE ARMED FORCES, PLEASE PROVIDE:
DATE YOU LEFT THE UK..... DATE YOU RE-ENTERED THE UK .....

SUMMARY CARE RECORD

I consent to a basic Summary Care Record

Signed..... DATE .....

Print name.....

(If you do not wish to consent to summary care records, please fill out the opt out form attached)

PLEASE BRING ID WITH YOU WHEN YOU COME IN TO REGISTER
THANK YOU

Patient Questionnaire – Women Only

Name: .....

Date of Birth: .....

Periods

What age did you start your periods? .....

What age did you finish your periods? (if relevant) .....

Are you periods regular? .....

How many days in the cycle? .....

How long does the bleeding last? .....

Is the bleeding heavy? .....

Contraception

If you use contraception please state the type you use .....

If you are taking an oral contraceptive pill, how long have you been taking it? .....

Do you get any side effects? (Please state) .....

Have you had a cervical smear? (Please state the date as well if relevant) .....

Children

NAME	DATE OF BIRTH	DID YOU HAVE ANY COMPLICATIONS? (please state)

Have you had any miscarriages? If so, please give details:

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