

WELCOME TO THE GREENWICH PENINSULA PRACTICE

We would value some health information about you whilst we await your medical records to be transferred.

FULL NAME :

DATE OF BIRTH :

ETHNIC ORIGIN : (please tick the one that most accurately describes your race or ethnic group)

WHITE	MIXED	ASIAN OR ASIAN BRITISH	BLACK OR BLACK BRITISH	OTHER ETHNIC GROUPS
White British	White & Black Caribbean	Indian or British Indian	Black British	Chinese
White Irish	White & Black African	Pakistani or British Pakistani	Black Caribbean	Other
Any other white background	White & Asian	Bangladeshi or British Bangladeshi	Black African	Ethnicity not stated
	Any other mixed background	Any other Asian background	Any other Black background	Ethnic Category

MAIN SPOKEN LANGUAGE: (please use sheet) Code:

Please tick the appropriate box(es) below :

	Yes	No	FOR STAFF USE ONLY: Appointment made today for smoking cessation? Y/N
1. Are you currently a smoker?			
2. Would you like to receive smoking cessation advice?			
3. Have you ever smoked?			
If you yes, when did you give up? (give approx. date/year)			

	Yes	No	Not sure
4. Have you had your blood pressure checked in the last year?			
5. If you have, was the reading normal?			

6. Are you suffering from any of the following illnesses in the past or present?	Family history?		FOR STAFF USE ONLY: Appointment made today for the following (circle Y/N where applicable)
	Yes	No	
Asthma			Y/N
Chronic Obstructive Pulmonary Disease (COPD)			Y/N
Ischaemic Heart Disease (eg angina, heart attack)			Y/N
Hypertension (High Blood Pressure)			Y/N
Stroke			Y/N
Diabetes			Y/N
Epilepsy			Y/N
Mental Health Disorder			Y/N
Cancer			Y/N
Hypothyroidism			Y/N

Are there any other illnesses you are suffering from in the past or present, major or minor that have not been listed above? *(If there is please state briefly, otherwise leave blank).*

Operations/Surgery	
Other Medical Problems	

	Yes	No		Yes	No
7. Are you taking any medication for any of the above illnesses?			8. Do you have any drug or other allergies?		
Drug Name :					

For children Under 5 :

9. Have any of the following immunisations been received?	Yes	No		Yes	No
1 st Triple			1 st HIB		
2 nd Triple			2 nd HIB		
3 rd Triple			3 rd HIB		
MMR			PSB		
Measles			Measles/Rubella		
BCG					

For Women only

	Date	Result
10. When did you have your last cervical smear?		

Signature : Date :

ALCOHOL USERS DISORDERS IDENTIFICATION TEST (AUDIT) C

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
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?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ indicates hazardous or harmful drinking

CODE	MAIN SPOKEN LANGUAGE	TICK ONE BOX ONLY
13I		
13IS	Albanian	
13IO	Arabic	
13I1	Bengali	
13I2	Cantonese	
13IT	Croatian	
13I3	Czech	
13If	Dutch	
13I4	English	
13uT	Finnish	
13I5	French	
13IR	German	
13IV	Greek	
13I6	Gujarati	
13I7	Hausa	
13I8	Hindi	
13IQ	Italian	
13IW	Japanese	
13IX	Korean	
13IY	Lithuanian	
13IB	Mandarin	
13Iq	Norwegian	
13IC	Polish	
13ID	Portugese	
13IE	Punjabi	
13IF	Russian	
13wG	Slovenian	
13IG	Somali	
13IH	Spanish	
13Iv	Swedish	
13IK	Tamil	
13IZ	Turkish	
13Ia	Ukrainian	
13IL	Urdu	
13Ib	Vietnamese	
13IM	Yoruba	
13I andText	OTHER (please state)	