

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:

DO YOU WANT A SUMMARY CARE RECORD?

YES : Do nothing and a record will be created for you

NO : Sign Opt Out Form and give to Receptionist

Please tick the appropriate box(es) below :

	Yes	No
1. Are you a smoker?		
If a smoker, how many per day		
2. Would you like to receive smoking cessation advice?		
3. Have you ever smoked?		
If 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?	
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>
Asthma				
Chronic Obstructive Pulmonary Disease (COPD)				
Ischaemic Heart Disease (eg angina, heart attack)				
Hypertension (High Blood Pressure)				
Stroke				
Diabetes				
Epilepsy				
Mental Health Disorder				
Cancer				
If yes, please give the site/type of cancer				
Hypothyroidism				

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	
If relevant, do you have a Carer? (please give contact details)	

	Yes	No		Yes	No
7. Are you taking any medication ?			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 :

E.mail address :

ALCOHOL USERS DISORDERS IDENTIFICIATION 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