Dr J D Huck
Dr Jane O'Donnell
Dr S H Whitehead
Dr A D W Bone

GUILDHALL SURGERY, CLARE

ADULT 16 & OVER - NEW PATIENT INFORMATION

Personal Information

Surname:	Title:		
First Name (s):	Known as Name:		
Date of Birth:	Age:		
Full Address (Inc. Postcode):			
Home Tel:	Mobile No:		
Work No:	E-Mail Address:		
Occupation:	Marital Status:		
I consent to receiving information from the practice or being contacted by: **(Please tick)**	Home No (Inc. SMS)	Mobile No (Inc. SMS)	E-mail

By giving us consent to use your contact telephone numbers, you are agreeing to receive SMS and voice messages (this includes appointment confirmations, health related invitation, updating personal details)

Medical Information

Please list any serious illnesses / operations / accidents / disabilities (and for women any pregnancy related problems) and the year they took place **(Continue on a separate sheet if necessary)**

Have you ever suffered from? **(If Yes, please state year first diagnosed)**

Epilepsy **Blindness/Glaucoma**

High Blood Pressure **Diabetes**

Heart Attack/Stroke **Depression**

Cancer **Asthma**

Eczema/Hay Fever **COPD**

Please list any medicines being taken and the amount? **(Or attach repeat medication list)**

Are you allergic to any medicines or have any Allergies? **(If Yes, please state)**

Do you have any other medical issues? **(If Yes, please state)**

Carer

Do you have a carer?

Are you a carer? **(If yes please give details)**

Will

Do you hold a Living Will? *(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness)*

YES ☐ **NO** ☐

Smoking

Do you smoke?

If 'No', have you ever smoked?

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?

Would you like advice on giving up smoking?

Alcohol

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

How many drinks do you have on average in a week?

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state their relationship to you, I.e. Mother/Father/Sibling/Grandparent, also state whether Male/Female

Next of Kin

Please give details below

Name	
Address	
Telephone Number	
Relationship	

SIGNATURE	**DATE**

Ethnic Group

This surgery, in line with other health care providers, collections information about the Ethnic origin of patients. This information can help us to meet the needs of the community and ensure that all our patients have equal access to the health care the practice provides.

Please note that we are not about citizenship or nationality but about the ethnic group to which you feel you belong. All the information we receive will be treated with the strictest confidence. It will not be used for any other purpose and will not be revealed to anyone outside the surgery.

Please complete the form below by ticking the box with the ethnic group you feel you belong to. If you are a descendant from more than one group, please tick the one you feel you most belong to, or chose the 'any other ethnic group' option.

A	**White**	**British**	
B	**White**	**Irish**	
C	**White**	**Any other white background**	
D	**Mixed**	**White and Caribbean**	
E	**Mixed**	**White and Black African**	
F	**Mixed**	**White & Asian**	
G	**Mixed**	**Any other mixed background**	
H	**Asian or Asian British**	**Indian**	
I	**Asian or Asian British**	**Pakistani**	
J	**Asian or Asian British**	**Bangladeshi**	
K	**Asian or Asian British**	**Any other Asian background**	
L	**Black or Black British**	**Caribbean**	
M	**Black or Black British**	**African**	
N	**Black or Black British**	**Any other black background**	
O	**Other Ethnic Group**	**Chinese**	
P	**Other Ethnic Group**	**Any other ethnic group**	

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