Welcome to the Kings Road Medical Centre

Thank you for completing this questionnaire. All information you give is confidential and will be held on your medical records. Please could you:

Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS**

Provide a specimen of urine

Your name:	
Your address:	
Your date of birth:	
Your email address:	
We may occasionally communicate with you by SMS or email. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do **NOT** wish to be contacted by email or SMS. ☐	
Who should we contact in an emergency?	
Name:	
Their relationship to you:	Their date of birth:
Their telephone number:	

Ethnicity

What is your country of birth? _____ What is your first language? _____

☐ White British	☐ Black other – Asian	☐ Chinese
☐ Other White ethnic group	☐ Other Black ethnic group	☐ Vietnamese
☐ Black British	☐ Indian	☐ Other Asian ethnic group
☐ Black Caribbean	☐ Pakistani	☐ I do not wish to state my ethnic group
☐ Black African	☐ Bangladeshi	☐ Other ethnic group (please state): _____

Please tick the box (one only) which best describes your ethnic origin:

Social Habits

Smoking: please tick the box that applies to you

☐ I am a SMOKER — How many per day? _____

☐ I am an EX-SMOKER — When did you stop smoking? _____

☐ I have NEVER SMOKED

Alcohol: 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?

One standard drink is: 1 single measure of spirits, 1 small glass of wine, half a pint of beer, lager or cider. A bottle of wine is 9 units

☐ 1 - 2 ☐ 3 – 4 ☐ 5 - 6 ☐ 7 - 9 ☐ 10+

How often do you have 6 or more standard drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Measurements

Height Feet/inches: _____ or Metres: _____ **Weight** Stones: _____ or Kg: _____

Waist Please measure around your waist in line with your belly button Inches: _____ Centimetres: _____

Exercise Do you take exercise that lasts for at least 20 minutes per session? ☐ Yes ☐ No

If Yes, how many times a week? ☐ 1 ☐ 2 ☐ 3+

Do you work?

☐ Employed ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired

What is your current occupation? _____

PLEASE TURN OVER TO COMPLETE THE REST OF THIS FORM

Carer/Housebound information

Do you have a Carer? ☐ Yes Name and contact no. of Carer: _____

Are you a Carer? ☐ Yes Name of person you care for: _____

Are you housebound? ☐ Yes

Family History

Have any of your close family (parents/brother/sister) had any of these illnesses or conditions?

		Details, for example Father, Mother, Sister
☐	Raised cholesterol	
☐	Stroke	
☐	Heart disease before the age of 60	
☐	Heart disease after the age of 60	
☐	Asthma	
☐	Cancer	
☐	Diabetes	

Past medical history

Please list with dates any **significant** current or past illnesses, operations or allergies

ILLNESS, OPERATION OR ALLERGY	**DATE**

Women only

Are you pregnant? ☐ Yes ☐ No If Yes, when is your baby due? _____

When was your last cervical smear examination? _____ Result: _____

When was your last Breast screening X-ray (mammogram)? _____ Result: _____

What type of contraception do you use, if any?

☐	Oral contraception (the Pill)	☐	Diaphragm	☐	Contraception not needed
☐	Condom (sheath)	☐	Patch (transdermal)	☐	No current contraception
☐	Depot Injection	☐	Ring (Nuvaring)	☐	Other–Please state ……..……..
☐	Coil (IUD – Intrauterine)	☐	Implant (Implanon/Nexplanon)		

Drugs and Medications If you require any medication, you must make an appointment with a Doctor for this to be issued. Please ensure you bring your repeat medication slip with you to the appointment.

THANK YOU FOR YOUR TIME AND YOUR HELP IN COMPLETING THIS QUESTIONNAIRE

Issuing of the registration documents does not guarantee registration with this Practice

For office use only

Proof of ID seen: ☐ Yes ☐ No

Type: _____ Initials/Date: _____

Proof of address seen (for example Utility Bill): ☐ Yes ☐ No

Type: _____ Initials/Date: _____