

FP1001

Number

HALCYON MEDICAL

SURNAME/FAMILY NAME

FORENAMES

TERM-TIME ADDRESS

HOME ADDRESS

Tel No:

Tel No:

Mobile No:

Email Address:

Date of Birth

Nationality

Sex [M / F]

D	D	M	M	Y	Y
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University & Course Duration

Job Title if Non-Student

Born in UK YES / NO

Date of Entry to UK:

D	D	M	M	Y	Y
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Do you consent to us contacting the Registry Dept. to confirm your personal details YES / NO

MEDICAL HISTORY

1. Do any of your immediate family suffer from? (circle any relevant)

DIABETES / EPILEPSY / ASTHMA / HEART DISEASE / HIGH BLOOD PRESSURE / BLOOD DISORDERS

2. Do you have? (circle any relevant)

DIABETES / EPILEPSY / ASTHMA / HEART DISEASE / HIGH BLOOD PRESSURE / BLOOD DISORDERS / CHRONIC KIDNEY DISEASE

3. Do you have any other ongoing physical or mental problems (including recent operations?)

4. Please list any current medication you are taking including contraception.

5. Do you have any allergies including drugs / medicines?

YOUR LIFESTYLE

Smoking

Amount NEVER / EX-SMOKER / CURRENT SMOKER
 Type of Tobacco CIGARETTES / CIGARS / PIPES / HAND-ROLLED / CHEWING
 N° per day _____
 If Ex-Smoker, Date Stopped ___/___/___

Exercise

Amount NEVER / LIGHT / MODERATE / HEAVY
 N° of Hrs / Week 0 1-2 3-5 6+
 Type of Exercise _____

Alcohol

F.A.S.T

1drink = 1 glass wine / 1 measure spirits / ½ pint beer or lager

For the following questions please write the underlined letter which best applies in the appropriate box

NEVER / LESS THAN MONTHLY / MONTHLY / WEEKLY / DAILY OR ALMOST DAILY

1. *Men* How often do you have **8** or more drinks on 1 occasion? []
Women How often do you have **6** or more drinks on 1 occasion? []
2. How often during the last year have you been unable to remember what happened the night before because you had been drinking? []
3. How often during the last year have you failed to do what was normally expected of you because of your drinking? []

For the following question please write the underlined letter which best applies in the appropriate box

NO / YES, BUT NOT IN THE LAST YEAR / YES, IN THE LAST YEAR

4. Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down? []

Contraception and Sexual Health

Are you sexually active? YES No

If YES: Do you use condoms **every time** for protection against sexually transmitted diseases? YES No

Have you ever been tested for sexually transmitted diseases? YES / No
 If YES: Swabs Bloods Urine Date ___/___/___

Do you use Contraception? YES No

If YES: What type: _____

If you are female and 25 or over:

Have you had a cervical smear in this country?
 YES: Date ___/___/___ Place _____

NO: Do you wish to have one? YES Advised Book Appointment
 No I do not wish to have a cervical smear:

Dissent Form Signed

:: FOR OFFICIAL USE ::

Height _____ cms Weight _____ kg B/P _____ / _____

Vaccinations

	Covered	Date	Given	Batch	Exp. Date
Tetanus	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	_____	___/___/___
MMR	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	_____	___/___/___
Men C	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	_____	___/___/___
Influenza	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	_____	___/___/___
BCG	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	_____	___/___/___

Signed _____ Date ___/___/___

:: PATIENT HAS CHRONIC DISEASE ? YES : NOTES IN CHRONIC DISEASE BOX ::

PATIENT PROFILING FORM

Patient identification number _____

Tick only one box in answer to each question

What do you consider to be your ethnic origin?

- | | | | |
|-----------------------------------|--------------------------|------------------------|--------------------------|
| White UK (English/Welsh/Scottish) | <input type="checkbox"/> | Pakistan | <input type="checkbox"/> |
| Irish | <input type="checkbox"/> | Indian | <input type="checkbox"/> |
| White (other) | <input type="checkbox"/> | Thai | <input type="checkbox"/> |
| Black Caribbean | <input type="checkbox"/> | Vietnamese | <input type="checkbox"/> |
| Black African | <input type="checkbox"/> | Bangladeshi | <input type="checkbox"/> |
| Black (other) | <input type="checkbox"/> | Sri Lankan | <input type="checkbox"/> |
| Japanese | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Chinese | <input type="checkbox"/> | <i>Patient refused</i> | <input type="checkbox"/> |

In which language would you like to receive written information?

- | | | | |
|-----------|--------------------------|------------------------|--------------------------|
| English | <input type="checkbox"/> | Bengali | <input type="checkbox"/> |
| Punjabi | <input type="checkbox"/> | Sylheti | <input type="checkbox"/> |
| Pushto | <input type="checkbox"/> | Hindi | <input type="checkbox"/> |
| Urdu | <input type="checkbox"/> | Creole | <input type="checkbox"/> |
| Gujarati | <input type="checkbox"/> | Vietnamese | <input type="checkbox"/> |
| Cantonese | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Braille | <input type="checkbox"/> | <i>Patient refused</i> | <input type="checkbox"/> |

In which spoken language would you prefer us to provide a service to you

- | | | | |
|----------------------------------|--------------------------|------------------------|--------------------------|
| English | <input type="checkbox"/> | Bengali | <input type="checkbox"/> |
| Punjabi | <input type="checkbox"/> | Sylheti | <input type="checkbox"/> |
| Pushto | <input type="checkbox"/> | Hindi | <input type="checkbox"/> |
| Urdu | <input type="checkbox"/> | Creole | <input type="checkbox"/> |
| Gujarati | <input type="checkbox"/> | Vietnamese | <input type="checkbox"/> |
| Cantonese | <input type="checkbox"/> | Mirpuri | <input type="checkbox"/> |
| British Sign Language | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Do You Need A Translator? | <input type="checkbox"/> | <i>Patient refused</i> | <input type="checkbox"/> |

What is your faith or religion, if any?

- | | | | |
|-------------------|--------------------------|-------------------------------|--------------------------|
| Islam | <input type="checkbox"/> | Buddhism | <input type="checkbox"/> |
| Sikhism | <input type="checkbox"/> | Christianity (Anglican) | <input type="checkbox"/> |
| Judaism | <input type="checkbox"/> | Christianity (Roman Catholic) | <input type="checkbox"/> |
| Hinduism | <input type="checkbox"/> | Christianity (Other) | <input type="checkbox"/> |
| Jehovah's Witness | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| Atheist | <input type="checkbox"/> | <i>Patient refused</i> | <input type="checkbox"/> |
| None | <input type="checkbox"/> | | |