Have you previously been registered at this surgery	**YES/NO**	**Are you resident with any patient registered with Gade Surgery. NAME:**	**YES/NO**
Evidence of residency in practice area seen by:	*Initials*	**Photographic ID seen by:**	*Initials*

NAME		DATE OF BIRTH	
ADDRESS POSTCODE	CONTACT NUMBERS (inc dialing code) HOME WORK MOBILE* I am happy to receive text messages from the practice where essential to my care — Yes / No ***Please tick to confirm (NB we are unable to accept "shared" mobiles for this purpose.***	DATE	COUNTRY OF ORIGIN RELIGION

SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED ☐ WITH PARTNER ☐

FAMILY HISTORY

	ALIVE		**IF DEAD**		
	FIRST NAME	YEAR OF BIRTH	ANY SERIOUS ILLNESS	CAUSE OF DEATH	AGE AT DEATH
MOTHER					
FATHER					
BROTHERS:					
1					
2					
3					
SISTERS:					
1					
2					
3					
HUSBAND/ WIFE					
CHILDREN:					
1					
2					
3					
4					
5					

Have any relations had any of the following:-

DISEASE OR ILLNESS	WHICH RELATION?	DISEASE OR ILLNESS	WHICH RELATION?
Heart Attack		Stroke	
Diabetes		Mental Illness	
High Blood Pressure		Asthma/Eczema	
Cancer		Epilepsy or Fits	

If so give details below:

What is your present occupation?	What previous occupations have you had?	What is the present occupation of your husband/wife/Partner?

TOBACCO DAILY: (if you do not smoke please write NONE) If you are an ex-smoker, when did you stop?

Cigars: Cigarettes: Pipe (oz): Would you like help to give up smoking: YES ☐ NO ☐

PAST ILLNESSES

What illnesses or operations have you had in the past?	Date (approximately)

This practice has agreed to take part in the upload of the Summary Care Record to support emergency care. If you need further information, please ask for a leaflet at reception.

Have you any dependent relatives living with you?	Have you any special handicaps?
Do you take care of someone else not living with you?	Do you have a regular carer who looks after you?

Please ask at Reception if you would like information on Carers in Hertfordshire for help and support or wish to referred to the support team

Are there any medicines or drugs that have disagreed with you or to which you are allergic?	What drugs or medicine?	What happens?
Please state what tablets or medicines you take from the doctor or hospital	Name	How often?

Please state what tablets or medicines you take from the chemist such as:-
Laxatives, pain killers, vitamins or nerve pills.

How often?

Have you ever misused drugs or solvents?	Have you any medical problems at the moment?

Have you any problems that it might help your doctor to know regarding your personal life, your childhood, your education, your family, your home life or your accommodation?

How much exercise do you take?	Is there anything special or unusual about your diet?

Please state what immunisations you have had e.g. tetanus, diptheria, whooping cough, polio, MMR, rubella or German measles, cholera, typhoid etc.	Date	Immunisation

WOMEN

BIRTHS

	DATES	COMPLICATIONS OF PREGNANCY	PROBLEMS OF DELIVERY	WEIGHT
1				
2				
3				
4				

MISCARRIAGES

	DATES	HOW MANY MONTHS?	WOMB SCRAPED?
1			
2			
3			

When did you last have a cervical smear?
Where?
What was the result?

What, if any, form of contraception do you use?

Have you ever had a mammogram or other breast cancer screening? If so, what and when?

Blood pressure: Weight: Height: BMI:

Urine: protein: glucose:: other:

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions. Please also indicate where English is not your first language and whether you will have difficulty communicating with your doctor as a result.

Choose ONE section and then tick ONE box to indicate your background.

Name.....Date of Birth.....

White

	A	British
	B	Irish
	C	Any other white background please write in below

Mixed

	D	White and Black Caribbean
	E	White and Black African
	F	White and Asian
	G	Any other mixed background please write below

Asian or Asian British

	H	Indian
	J	Pakistani
	K	Bangladeshi
	L	Any other Asian background please write below

Black or Black British

	M	Caribbean
	N	African
	P	Any other black background

Other ethnic group

	R	Chinese
	S	Any other ethnic group please write below

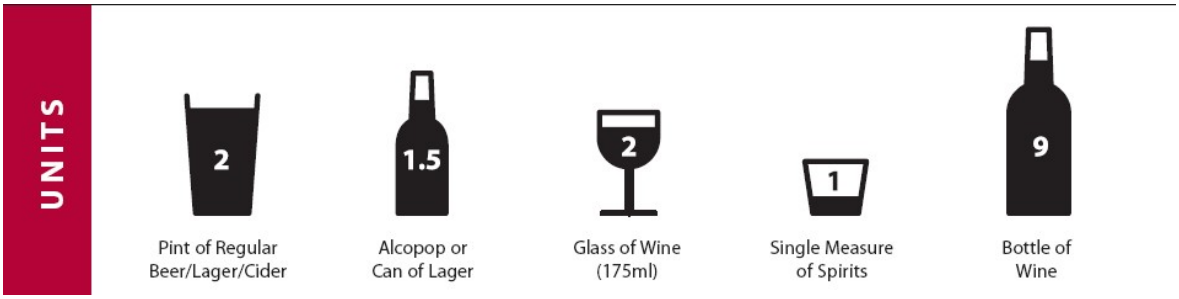
	Z	Not Stated

Language

	#13Z69	First language not English
	#13oB	Difficulty communicating because of language

Audit-C questionnaire

Please complete the questionnaire at the bottom of this page and return it to the surgery with the rest of your paperwork.
Name:
DOB:



Alcohol Users Disorders Identification Test (AUDIT) C

Questions	Scoring System 0	1	2	3	4	Your Score
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