

# THE COLERIDGE MEDICAL CENTRE

CANAAN WAY • OTTERY ST MARY • DEVON EX11 1EQ

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**THIS INFORMATION WILL BE TREATED AS PRIVATE & CONFIDENTIAL**

Date Completed			Date of Birth	
Surname			Marital Status	
Forenames			Occupation	
Previous Names				
Address				
		Please tick preferred contact no.	Postcode	
E-mail address			Next of Kin (Name) Relationship: Contact Tel:	
Telephone				
Mobile				
If you are happy to receive messages via email or text(SMS) please complete the section below:				

*We will only text or email you with messages that are relevant to your ongoing health care e.g. appointment reminders, requests to contact your GP regarding tests or reviews, health screening opportunities etc. We respect your privacy and will only contact you in this way if you give us your permission. Please complete the consent section below.*

I consent to **receiving** text messages from the Coleridge Medical Centre      YES/NO

I consent to **receiving** email messages from the Coleridge Medical Centre      YES/NO

I accept that it is my responsibility to inform the Coleridge Medical Centre if I change my mobile phone number or email address. Signature .....

## MEDICAL HISTORY

Are you in good health?	YES / NO
Have you had any previous, serious or recurrent illnesses, accidents or operations?	YES / NO

Illness/Accident/Operation	Year	Hospital (if appropriate)

Are you taking any medication?	YES / NO	
Medication	Dose	For how long?

How often do you have a drink containing alcohol? (please circle your answer)	Never, Monthly or less, 2-4 times/month, 2-3 times/week, 4 or more times/week
How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2, 3 or 4, 5 or 6, 7 or 8, 10 or more (please circle your answer)
How often do you have 6 or more standard drinks on one occasion?	Never, Less than monthly, Monthly, Weekly, Daily or almost daily (please circle your answer)
Are you a	Smoker      ex smoker      never smoked
How much do you smoke per day and in what form?	
Are you allergic to anything?	
Are you visually impaired?	YES / NO

The following chart shows amounts of exercise over a 4 week period.

Please tick the box that describes the amount of exercise you take in a month.

Activity of 20 minutes	Duration in previous 4 weeks	Tick
Vigorous	On 12 or more occasions	<input type="checkbox"/>
Moderate/vigorous	On 12 or more occasions	<input type="checkbox"/>
Moderate	On 12 or more occasions	<input type="checkbox"/>
Moderate/vigorous	On 5-11 occasions	<input type="checkbox"/>
Moderate/vigorous	On 1-4 occasions	<input type="checkbox"/>
None		<input type="checkbox"/>

**IN THE CASE OF WOMEN**

1. How many children have you had?				
2. Have you had a miscarriage or stillbirth?				
3. Are you on an oral contraceptive pill?			If yes, name of pill:	
4. How long have you been taking the oral contraceptive?				
5. Do you have an IUCD (coil) fitted?			If yes, when was it fitted?	
6. Have you had a breast check?	Doctor/Nurse		YES / NO	Date
	Mammogram		YES / NO	Date
7. Have you had a cervical smear test?			YES / NO	Date

**PREVIOUS IMMUNISATIONS**

	Date		Date		Date		Date
Whooping Cough		MMR		Measles		Diphtheria	
Polio		Tetanus		Rubella		Others	

**FAMILY HISTORY**

It would be helpful to know if anyone in your immediate family suffers or has died from any of the following illnesses. Please tick below:

Relation	Glaucoma	Angina	Diabetes	High Blood Pressure	Asthma	Thyroid Disease
Father						
Mother						
Sisters / Brothers						
Children						

If there have been deaths in the family from another cause please state below giving age and cause of death if known:-

Do you have any disability?	YES / NO
Do you have any family or social problems?	

Do you care for somebody who could not manage without your help?	YES / NO	If YES	Name:
			Address:
Are they a child under 18?			
An adult with physical disability or illness?			
An adult with dementia or other mental health issues			
Are you cared for by somebody?	YES / NO		
Would you like a Carers Health Check?	YES / NO		

**CURRENT**

Weight		Height		Blood Group	
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**PLEASE BRING THIS FORM WITH YOU WHEN YOU ATTEND YOUR REGISTRATION MEDICAL**