

**BARONSCOURT SURGERY MEDICAL HISTORY FORM**

It would assist the Doctors in the practice if you could provide information about yourself and your medical history, as it can be sometime before we receive your medical records from your previous GP. The information provided will be treated with the strictest confidence and will be kept in your medical record. Please complete both sides as fully as possible.

First Name: \_\_\_\_\_

Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status: \_\_\_\_\_

Male/Female (*please circle*)

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Home Phone No: \_\_\_\_\_

Mobile Phone No: \_\_\_\_\_

Email address: \_\_\_\_\_

**If you would like to receive our Practice Newsletter via email please provide your email address in the space provided above.**

**By providing your mobile number you will automatically be registered with our appointment reminder service via text message. Our aim is to send a text reminder approximately 24 hours prior to your appointment. There are certain occasions when this is not always possible but we will do our best to notify patients of this. Please remember if you are unable to make your appointment please contact us to cancel.**

Place of Birth: \_\_\_\_\_

If you were born **outside the U.K** please give the date you first arrived in the U.K: \_\_\_\_/\_\_\_\_/\_\_\_\_

If you were born in the U.K but have been living abroad please tell us:

Date you left: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date you arrived back: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Next of Kin Details:**

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address (inc postcode): \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

**Name of Previous GP:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Are you allergic to any medication? (if yes please name)

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Are you on any current/regular medication? YES/NO

If yes please list by name and dose (inc contraceptive pill)

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Please give us details of any illnesses, chronic diseases, accidents, hospital admissions, investigations or operations you may have had in the past. (Ladies please include pregnancies and childbirth):

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Are you a current smoker? YES/NO Have you ever smoked? YES/NO

If **YES**, How much do/did you smoke each day?

Cigarettes? \_\_\_\_\_ Cigars? \_\_\_\_\_ Pipe? \_\_\_\_\_

*If you are a current smoker we are able to offer help if you wish to stop, either within the practice or by referring you to a smoking cessation clinic. Please make an appointment with a Doctor if you wish to discuss this further.*

How many units of alcohol do you normally drink per week? \_\_\_\_\_

*\*A unit of alcohol is equivalent to 1 glass of wine, 1 measure of spirits or a ½ pint of beer or lager.*

What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_

Have you ever had a cervical smear? \_\_\_\_\_ (Ladies only)

If YES, when and where? \_\_\_\_\_ (Date if known) \_\_\_\_\_

Do any of your close relatives (Parents, Children, Brothers/Sisters) suffer from either of the following?(Please detail)

**HEART DISEASE** YES/NO \_\_\_\_\_ Age: \_\_\_\_\_

**STROKE** YES/NO \_\_\_\_\_ Age: \_\_\_\_\_

**DIABETES** YES/NO \_\_\_\_\_ Age: \_\_\_\_\_

**Ethnic Origin** (please circle your ethnic group)

White British-                      White Irish-                      Other white background (please state)-

Asian Indian-                      Asian Pakistani-                      Other Asian background (please state)-

Asian Bangladeshi-                      Black Caribbean-                      Other Black background (please state)-

Black African-                      Chinese-                      White & Black African-  
White & Asian-                      Black & Asian-                      White & Black Caribbean-

Any other ethnic group (please state) \_\_\_\_\_ Other mixed race (please state) \_\_\_\_\_

I DO NOT wish my ethnic origin to be recorded (please tick)