**Kinmylies Medical Practice**

New patient health information form

|  |  |  |
| --- | --- | --- |
| Name |  | |
| Preferred to be known as |  | |
| Date of birth |  | |
| If < 16, name of parent / guardian |  | |
| Address  Do you have a key safe box?  In case of a home visit | Yes □ ..Number? No □ | |
| Telephone | Mobile |  |
| Landline |  |
| Work |  |
| Preferred first point of contact |  |
| Please confirm this is your  OWN phone number |  |
| I agree to be contacted by SMS messaging | Yes □ No □ | |
| Email address |  | |
| Occupation |  | |
| If school aged, which school do you attend? |  | |
| Next of kin details | Name | Contact details |
| Power of  Attorney held | Yes □ No □ | Name  Contact details |
| In case of emergency  Contact: | Name | Contact details |
| Is there anyone you specifically give us permission to share your medical details with? | Name | Contact details |
| Are you a carer? | Yes □ No □ | |
| Details of person you care for |  | |
| Do you require an interpreter?  Which language? | Yes □ No □ | |
| Are you a veteran? | Yes □ No □ | |

Medical History / Conditions / Operations

|  |  |
| --- | --- |
| Condition / diagnosis | Date of diagnosis / date of surgery |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Prescribed medication

|  |  |  |  |
| --- | --- | --- | --- |
| Medication  (name) | Dose | Frequency  (how many a day) | Preferred supply  (1 or 2 months) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Over the counter medication

|  |  |  |
| --- | --- | --- |
| Medication | Dose | Frequency |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Preferred pharmacy

|  |
| --- |
|  |

Allergies

|  |  |
| --- | --- |
| What are you allergic to? | What reaction did you have? |
|  |  |
|  |  |
|  |  |

Living will / advanced care plans / DNA CPR status

|  |  |
| --- | --- |
| Living will |  |
| Advanced care plan |  |
| DNA CPR |  |
| If you have any of the above, please ensure we keep a copy of them on file | |

Relevant family history

|  |  |
| --- | --- |
| Relative | Medical condition |
|  |  |
|  |  |
|  |  |

Smoking status

|  |  |  |  |
| --- | --- | --- | --- |
| Status | Type | Amount | Duration (years) |
| Current Smoker | Tobacco  E cigarettes  Vapes |  |  |
| Ex smoker |  |  |  |
| Never smoked |  |  |  |

**If you currently smoke we recommend that you try to stop. Do you wish to be referred to the**

**smoking cessation advice service?** **Yes □ No □**

**You can also self-refer by calling the cessation advice service on 01463 704619**

Exercise

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Exercise physically impossible |  | Avoids trivial exercise |  | Enjoys light exercise |  |
| Enjoys moderate exercise |  | Enjoys heavy exercise |  | Competitive athlete |  |

Alcohol - (Recommended limit 14 units for women and 21 units for men)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Within recommended limits  □ | Above recommended limits  □ | Stopped  □ | Current non drinker  □ | Teetotaller  □ |

Contraception

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Barrier (condoms) | Pill | Injection | Implant | Coil  Type  (if known) | Sterilised |

Anything else that we should know or you would like us to record -

|  |
| --- |
|  |

Office Use Only

Application status:­­­­­­­­­­­­­­­­­­­­­­­­

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Pharmacy logged |  | NOK details |  | Health questionnaire complete |  |
| Code SMS / Email consent in notes |  | Task to ED/LT |  | Document w/f to Practice Manager / Admin |  |
| If new Care Home resident – add to visit list. |  | Veteran |  | Keysafe (Admin) |  |
|  |  |  |  |  |  |