Name		**Title**	Mr	Mrs	Miss	Ms	Dr
Address							
	Telephone Number						
Date of Birth	**Mobile Number**						
Email Address							
Maiden name and previous names							

Gender Identity and Trans Status Monitoring

Which of the following options best describes how you think of yourself?

Woman (Including trans woman)		Man (Including trans man)	
Non-binary		In another way	

Is your gender identity the same as the gender you were assigned at birth?

Yes	No	Not stated

Sexual Orientation Monitoring

Which of the following options best describes how you think of yourself?

Heterosexual or Straight	
Gay or Lesbian	
Bisexual	
Other sexual orientation not listed	

Allergies - please list any allergies to medicines, food or other substances below

Please list any major illnesses

PLEASE ATTACH A LIST OF ALL CURRENT MEDICATIONS

Please list your regular medication

Medication	How often taken	Reason for taking medication	

PLEASE SPECIFY NOMINATED PHARMACY	

Please list any operations you may have had with the dates

Women:	When did you last have a smear?	Date and result		

Ethnicity:

British - white		Pakistani or British Pakistani	
Irish		Bangladeshi/British Bangladeshi	
Other white		Other Asian background	
White and Black Caribbean		Caribbean	
White and Black African		African	
White and Asian		Other Black background	
Other mixed background		Chinese	
Indian or British Indian		Other	

Have you ever smoked tobacco	Yes	No	**Ex-smoker date stopped**	
Current smoker - how many per day			**Ex-smoker how many per day**	
Do you use a Vape/E-Cigarette	Yes	No		

Religion (please state)	
Language spoken	

Carers

Do you need/have anyone who looks after you or your daily needs as carer?	Yes	No
If "Yes" would you like them to deal with your health affairs here?	Yes	No

(A receptionist can help with these arrangements)

Do you care for anyone else?	Yes	No

(If "Yes" ask the receptionist about carers support)

Do you or anyone in your household have a named social worker?	Yes	No

Military Veterans

Do you have a history of serving in the armed forces?	Yes	No

For the following questions please circle the answer which best applies

1 drink =1/2 pint of beer or one glass of wine or 1 single spirit.

This is one unit of alcohol	 Half pint of regular beer, lager or cider	 1 small glass of wine	 1 single measure of spirits	 1 small glass of sherry	 1 single measure of aperitifs	
...and each of these is more	 Pint of Regular Beer/Lager/Cider	 Pint of Premium Beer/Lager/Cider	 Alcopop or can/bottle of Regular Lager	 Can of Premium Lager or Strong Beer	 Can of Super Strength Lager	 Glass of Wine (175ml)  Bottle of Wine
			Scoring system			**Your score**
	0	1	**2**	3	4	
How often do you have a drink containing alcohol?	never	monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 to 2	3 to 4	5 to 6	7 to 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

Name:
Date of Birth: