**Text Messages**: Do you give consent to receive text messages Yes No

**Do you need an interpreter** Yes No

If so , which language.................................................................................................................

**Gender** (delete as appropriate)

Male (including trans men) Female (including trans women) Non-Binary/In another way (please state)................................................

If you have a preferred pronoun, tell us (e.g him, her, they)....................................................

Is your gender identifying the same as you were assigned at birth? Yes No

**Sexual orientation** (delete as appropriate)

Heterosexual or straight Lesbian or gay Bisexual Or another way (please state)

**Status** Single married widow divorced separated cohabiting child

**Occupation** .............................................................. **Currently employed**  Yes No

**Next of kin** : Name .................................................. Relationship.........................................

Address ....................................................................................................................................

Contact number.................................................................

Please list other members of your family who are registered at this practice

Name .....................................................DOB.................................Relationship.........................

Name.......................................................DOB.................................Relationship........................

**Present medication**: (including medication that is not prescribed ie over the counter preparations, herbal/homeopathic)

Name of drug........................................... Strength..................... How often taken..................

* .........................................................................................................................................
* ..................................................................................................................................................
* ...................................................................................................................................................

**Previous Important illnesses/operations**

Illness................................................ Date..........................Treatment.......................................

\*.............................................................\*...................................\*...............................................

\*.............................................................\*...................................\*...............................................

**Family Diseases**

Parent/Brother/Sister – heart disease first occurring under age of 60 Yes No

Parent/Brother/Sister – stroke first occurring under age of 60 Yes No

Parent/Brother/Sister – diabetes Yes No

Parent/Brother/Sister – breast cancer, colorectal cancer under age of 45 Yes No

Other diseases - Please give details.....................................................................................................

**Allergies** .....................................................................................................................................

**Smoking Status**

Never smoked Ex smoker/year stopped Vapes Cigarettes per day Roll ups

Pipe smoker Cigar smoker Cannabis/ recreational drugs

**Alcohol (per week)**

Stopped drinking alcohol Teetotaller Trivial < 1u/day Light 1-2u/day

Moderate 3-6u/day Heavy 7-9u/day Very heavy >9u/day

**Height** ...................................................  **Weight**..............................................................

**Cervical Screening – Smear Test**

Date of last smear............................................ Result : Normal Abnormal

Please give details of any abnormal smear with treatment received.......................................

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