FP1001 Number

HALCYON MEDICAL

SURNAME/FAMILY NAME FORENAMES

TERM-TIME ADDRESS HOME ADDRESS

Tel No: Tel No:
Mobile No:
Email Address:

Date of Birth Nationality Sex [M / F]

D	D	M	M	Y	Y

University & Course Duration Job Title if Non-Student

Born in UK YES / NO Date of Entry to UK:

D	D	M	M	Y	Y

Do you consent to us contacting the Registry Dept. to confirm your personal details YES / NO

MEDICAL HISTORY

1. Do any of your immediate family suffer from? (circle any relevant)
   DIABETES / EPILEPSY / ASTHMA / HEART DISEASE / HIGH BLOOD PRESSURE / BLOOD DISORDERS
2. Do you have? (circle any relevant)
   DIABETES / EPILEPSY / ASTHMA / HEART DISEASE / HIGH BLOOD PRESSURE / BLOOD DISORDERS / CHRONIC KIDNEY DISEASE
3. Do you have any other ongoing physical or mental problems (including recent operations?)

4. Please list any current medication you are taking including contraception.

5. Do you have any allergies including drugs / medicines?

YOUR LIFESTYLE

Smoking Amount NEVER / EX-SMOKER / CURRENT SMOKER
Type of Tobacco CIGARETTES / CIGARS / PIPES / HAND-ROLLED / CHEWING
Nº per day _____
If Ex-Smoker, Date Stopped ___/___/_____

Exercise Amount NEVER / LIGHT / MODERATE / HEAVY
Nº of Hrs / Week 0 1-2 3-5 6+
Type of Exercise _____

Alcohol F.A.S.T 1drink = 1 glass wine / 1 measure spirits / ½ pint beer or lager
For the following questions please write the underlined letter which best applies in the appropriate box
NEVER / **L**ESS THAN MONTHLY / **M**ONTHLY / **W**EEKLY / **D**AILY OR ALMOST DAILY

1. *Men* How often do you have **8** or more drinks on 1 occasion? [ ]
   Women How often do you have **6** or more drinks on 1 occasion? [ ]
2. How often during the last year have you been unable to remember what happened the night before because you had been drinking? [ ]
3. How often during the last year have you failed to do what was normally expected of you because of your drinking? [ ]

For the following question please write the underlined letter which best applies in the appropriate box
NO / YES, BUT NOT IN THE **L**AST YEAR / **Y**ES, IN THE LAST YEAR

4. Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down? [ ]

Contraception and Sexual Health
Are you sexually active? YES ☐ NO ☐

If YES : Do you use condoms **every time** for protection against sexually transmitted diseases ? YES ☐ NO ☐

Have you ever been tested for sexually transmitted diseases? YES / NO
If YES : Swabs ☐ Bloods ☐ Urine ☐ Date ___/___/_____

Do you use Contraception? YES ☐ NO ☐
If Yes : What type : _____

If you are female and 25 or over :
Have you had a cervical smear in this country ?
YES: Date ____/____/_____ Place _____

NO: Do you wish to have one? YES ☐ Advised Book Appointment ☐
NO ☐ I do not wish to have a cervical smear :
Dissent Form Signed ☐

:: FOR OFFICIAL USE ::

Height _____ cms Weight _____ kg B/P _____ / _____

Vaccinations

	Covered	Date	Given	Batch	Exp. Date
Tetanus	☐	___/___/___	☐	_____	___/___/___
MMR	☐	___/___/___	☐	_____	___/___/___
Men C	☐	___/___/___	☐	_____	___/___/___
Influenza	☐	___/___/___	☐	_____	___/___/___
BCG	☐	___/___/___			

Signed _____ Date ___/___/___

:: PATIENT HAS CHRONIC DISEASE ? YES : NOTES IN CHRONIC DISEASE BOX ☐ ::

CONFIDENTIAL

PATIENT PROFILING FORM

Patient identification number_____

Tick only one box in answer to each question

What do you consider to be your ethnic origin?

White UK (English/Welsh/Scottish)	☐	Pakistan	☐
Irish	☐	Indian	☐
White (other)	☐	Thai	☐
Black Caribbean	☐	Vietnamese	☐
Black African	☐	Bangladeshi	☐
Black (other)	☐	Sri Lankan	☐
Japanese	☐	Other	☐
Chinese	☐		
		Patient refused	☐

In which language would you like to receive written information?

English	☐	Bengali	☐
Punjabi	☐	Sylheti	☐
Pushto	☐	Hindi	☐
Urdu	☐	Creole	☐
Gujarati	☐	Vietnamese	☐
Cantonese	☐	Other	☐
Braille	☐		
		Patient refused	☐

In which spoken language would you prefer us to provide a service to you

English	☐	Bengali	☐
Punjabi	☐	Sylheti	☐
Pushto	☐	Hindi	☐
Urdu	☐	Creole	☐
Gujarati	☐	Vietnamese	☐
Cantonese	☐	Mirpuri	☐
British Sign Language	☐	Other	☐
Do You Need A Translator?	☐	*Patient refused*	☐

What is you faith or religion, if any?

Islam	☐	Buddhism	☐
Sikhism	☐	Christianity (Anglican)	☐
Judaism	☐	Christianity (Roman Catholic	☐
Hinduism	☐	Christianity (Other)	☐
Jehovah's Witness	☐	Other	☐
Atheist	☐		
None	☐	*Patient refused*	☐