**Kerrsland Surgery**

**New Patient Information**

|  |
| --- |
| **Preferred Title:** |
|  |
| **Surname:** |
|  |
| **Previous Surname if applicable:** |
|  |
| **First Names:** |
|  |
| **Preferred first name:** |
|  |
| **Gender:** |
|  |
| **Marital Status:** |
|  |
| **Date of Birth:** |
|  |
| **Address & Postcode:** |
|  |
| **Mobile Telephone:** |
|  |
| **Home Telephone:** |
|  |
| **Work Telephone:** |
|  |
| **Email Address:** |
|  |
| **Can we contact you by text if necessary?: Yes/No** |
|  |
| **Previous GP:** |
|  |
| **Next of kin name:** |
|  |
| **Next of kin contact number:** |
|  |

**If you are deaf, please indicate, by circling, which form of communication you would like to be contacted by.**

Hearing Loop Lip-Reading Sign Language British Sign Language Lipspeaker

Textphone Contact via Text Relay Translator/Interpreter

**Medical History**

Do you suffer from any of the following

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma |  | COPD |  |
| Diabetes |  | High Blood Pressure |  |
| Angina or Heart Attack |  | Stroke or TIA |  |
| Epilepsy |  | Depression/Anxiety |  |
| Atrial Fibrillation (irregular Heart beat) |  | Osteoporosis |  |

**List any other major medical conditions /operations below**

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**Medications - Please attach a printout from your previous GP, medication will not be available to order in practice or online without your previous GPs print out.**

**Please list any medication allergies:**

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| --- |
|  |
|  |
|  |

**Other health information:**

|  |
| --- |
| Are you a smoker? If yes how many per day |
| Units of alcohol consumed per week |
| Approximate date of last smear if applicable |