PATIENT HEALTH SUMMARY FORM

Zetland
MEDICAL PRACTICE

NAME……**DATE OF BIRTH**…….....

ADDRESS……

……**POSTCODE**:…….....

TELEPHONE NO:……..**MOBILE**……...

EMAIL ………**MARITAL STATUS**:…….....

NEXT OF KIN…….....**OCCUPATION**:……

DO YOU CARE FOR SOMEONE WHO IS PHYSICALLY OR MENTALLY DISABLED?
YES __ NO ___

If yes, have you involved Social Services? .....

Please fill in our carers registration form available to download or at Reception

Do you have a Learning Disability? YES __ NO __ If you have a support worker please give details:

……

Registered blind? YES __ Date registered ..... NO __
Partially Sighted? YES __ NO __

PAST MEDICAL HISTORY: Please list any serious illnesses, operations or accidents with approximate dates:-

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…….....
.....……

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SMOKING
Smoker __ Ex smoker __ Approximate date stopped _____
Never Smoked__

ALCOHOL
Current Drinker __ Ex Drinker __ Lifelong Teetotal __
Approximately how many units do you drink a week? __ (1 unit = ½pint beer/lager/cider, 1 glass of wine, 1 measure of spirits, 1 small glass of sherry)

For the following questions please circle the answer which best applies.
(1 drink = ½ pint beer or 1 glass of wine or 1 single spirit)

1. How often do you have eight or more drinks on one occasion?

Never	*Less than Monthly*	*Monthly*	*Weekly*	*Daily or almost daily*

2. 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*

3.How often during the last year have you failed to do what was normally expected of you because of your drinking?

Never	*Less than Monthly*	*Monthly*	*Weekly*	*Daily or almost daily*

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

No	*Yes, but not in the last year*	*Yes, during the last year*

EXERCISE
(Please describe the type of exercise you do ie walking, cycling, golf, aerobics, gym etc. and how often you do it.)
……
……

IMMUNISATIONS
Please list all immunisations and date administered.
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……
……
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MEDICATION

Please ATTACH a repeat request slip from your previous practice – if not available please list - include dosage and also supply medication boxes/bottles:

Practice Procedure re Repeat prescriptions:

Please note that when your repeat prescription has been signed it will be sent directly to your local pharmacy for collection. If you would prefer to collect your prescription from the surgery please mark this clearly on your prescription request.

ALLERGIES: List all known allergies:

Please record your ethnicity and preferred first language:

White British	__	White Irish	__
White – Any Other Ethnic Group*	__	Black/White Caribbean mixed	__
Black/White African mixed	__	Asian/White mixed	__
Any Other Mixed Ethnic Group*	__	Indian	__
Pakistani	__	Bangladeshi	__
Asian – Any Other Ethnic Group*	__	Chinese	__
Black Caribbean	__	Black African	__
Black – Any Other Ethnic Group*	__	Any Other Ethnic Group *	__

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PREFERRED FIRST LANGUAGE ……

*If you wish to supply additional details, enter here
.....

If you do not want your ethnicity
recorded tick here ☐ 9SD.. 9SD..

WOMEN ONLY

Number of all pregnancies: (Please give dates of delivery and any problems – including miscarriages and terminations of pregnancy)
……..
……..
……..
…….....DATE OF LAST SMEAR …….
RESULT: .....
When next due……..

CURRENT CONTRACEPTION:……

HRT.....Date commenced …….....

FOR OFFICE USE ONLY:

Please book TELEPHONE CONSULTATION ___ APPOINTMENT __
re repeat medication. URGENT __ NON URGENT __