**Kerrsland Surgery**

**New Patient Information**

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| **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

**Please list any significant past medical history with approximate years**

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**Include operations, chronic conditions and major diagnoses:**

**Please list all regular medications as accurately as possible. Alternatively, you can attach a printout of your medications from your previous GP.**

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**Please list any medication allergies:**

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**Other health information:**

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| --- |
| How much do you smoke per day  |
| Units of alcohol consumed per week |
| Approximate weight |
| Approximate height |
| Approximate date of last smear if applicable |