CLINICAL INFORMATION - Page 1 of 2

(Please give this sheet to the Doctor or Nurse)

As a new patient, completing this form helps us get a detailed overview of your health. This form is confidential and will only be kept in your confidential medical record.

Name .... Date of birth..................................

Your **current or past health problems** *(circle any relevant known conditions)*

Skin problems	Yes ❑ No ❑	Diabetes/high blood sugar/ gestational diabetes	Yes ❑ No ❑
Leg ulcers	Yes ❑ No ❑	High blood pressure	Yes ❑ No ❑
Vision problems/glaucoma	Yes ❑ No ❑	High cholesterol	Yes ❑ No ❑
Unusual or severe infection/ meningitis	Yes ❑ No ❑	Heart disease/chest pain/ angina/ rheumatic fever	Yes ❑ No ❑
Teeth/gum problems	Yes ❑ No ❑	Liver disease/jaundice/gallstones	Yes ❑ No ❑
Asthma/COPD/breathing problems/ chronic cough	Yes ❑ No ❑	Coeliac disease/malabsorption/ Crohn's disease/Ulcerative colitis	Yes ❑ No ❑
Bladder/kidney/prostate problems	Yes ❑ No ❑	Stomach ulcers/reflux/indigestion	Yes ❑ No ❑
Thyroid problem	Yes ❑ No ❑	Hepatitis C/HIV - AIDS	Yes ❑ No ❑
Anaemia/low blood count	Yes ❑ No ❑	Head injury	Yes ❑ No ❑
Chronic pain	Yes ❑ No ❑	Sleep apnoea/ sleep disorder	Yes ❑ No ❑
Unexplained weight loss	Yes ❑ No ❑	Seizures/epilepsy	Yes ❑ No ❑
Cancer/lymphoma/leukeamia	Yes ❑ No ❑	Anxiety/depression	Yes ❑ No ❑
DVT/blood clots/bleeding disorder	Yes ❑ No ❑	Other mental health condition	Yes ❑ No ❑
Arthritis/ Lupus/autoimmune or connective tissue disease	Yes ❑ No ❑	Stroke/TIA/other brain or neurological problem	Yes ❑ No ❑
Gynaecological problems or breast lumps	Yes ❑ No ❑	Migraine/recurrent or severe headache	Yes ❑ No ❑
Hearing loss	Yes ❑ No ❑	Blood transfusion	Yes ❑ No ❑
Operations/surgery (please list)	Yes ❑ No ❑		

Have any **family** members had any of the following? *(continued over page)*

High blood pressure or high cholesterol	Yes ❑ No ❑	Stroke	Yes ❑ No ❑
Heart disease (aged under 65 years)	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑
Sudden cardiac death (aged under 65)	Yes ❑ No ❑	Bleeding or blood clotting disorder	Yes ❑ No ❑

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Name:.. Date of Birth :..

Cancer (incl skin cancer) Type(s):	Yes ❑ No ❑	Anxiety/depression/suicide	Yes ❑ No ❑
Hereditary conditions or those detected at birth or that run in the family:	Yes ❑ No ❑	Dementia especially young onset	Yes ❑ No ❑

Some clinical problems are more (or less) likely to occur in people of particular ethnic backgrounds. If you wish us to be aware of your ETHNIC ORIGINS, please record here:..

Your OCCUPATION(S) ....

PHYSICAL ACTIVITY (Please CIRCLE your activity level over the last 4 weeks)

INACTIVE (1)	LIGHT (2)	MODERATE (3)	HEAVY (4)	VERY HEAVY (5)

MEDICATION LIST including over-the-counter remedies

NAME	STRENGTH	DOSES	REASON

ALLERGIES TO MEDICATION: ....

OTHER SIGNIFICANT ALLERGIES (e.g. to nuts, eggs):...

Do you smoke tobacco? Yes ❑ No ❑ If no, are you an ex-smoker? Yes ❑ No ❑

Do you drink alcohol? Yes ❑ No ❑ Have you any concerns about your alcohol intake? Yes ❑ No ❑

FOR WOMEN: Date of last pap smear? .... Any abnormal pap smears in past? Yes ❑ No ❑

Form of contraception (if any) ....

Any other Medical Information you feel may be relevant: