Welcome to Jiggins Lane Medical Centre

You can register for our on-line appointment booking and prescription ordering service once you have been accepted and registered at the practice, please ask at reception for appropriate forms.

Date_____

Please help us by filling in this questionnaire, it may take time for your previous medical records to reach us.

NAME_____DOB _____
ADDRESS _____ TEL _____
Please circle if you consent for practice to contact you via text messaging. Y/N
OCCUPATION_____PARTNERS OCCUPATION_____
If a student which college do you attend ? _____

Married Single Divorced Widow Separated

Names, ages & relationship of other people living at your address
_____
Next of Kin_____

- **Are you a Carer, if so who for ?**
  _____

Are you Cared for?_____
Have you been registered with this practice before? Yes/No

Are there any children under 16 years in the household? Yes/No. If so are you intending to register all of them in this practice? Yes/No. If no, who are they registered with?
Name & address of previous Doctor including the postcode
_____
Have you ever lived or worked abroad, if so when _____ which country _____Place of birth_____

- **Do you smoke Yes/No If yes, How many a day**
  _____

Do you take exercise Yes/No Details _____

Please list major illnesses you have had in the past or suffer from now (e.g. heart disease, chest disease, nervous complaints, operations or other conditions needing treatment by a doctor. Give dates if possible.
_____
Do any of your close relatives suffer from illness such as diabetes, blood pressure, heart trouble or stroke?
Please give details:
_____

Do you take any tablets or medicine regularly including 'the pill'. If so please list with strength and when you take them.
_____

Do you use any 'non prescribed drugs', if so please list.
_____
Are you allergic to anything especially tablets or medicine? _____

Have you had a Rubella (German Measles) vaccination **Yes/No**
Have you had a Tetanus vaccination **Yes/No**
Have you had Hepatitis A or B vaccinations **Yes/No**

Females only – Have you had a cancer smear test **Yes/No**
Date_____ Where taken _____
Have you had a mammogram **Yes/No**
Date taken _____
Have you had HPV vaccination _____ **Yes/No**

Children's section

Immunisation	**Yes**	**No**	**Date**
Whooping Cough			
Tetanus/Diphtheria/Polio			
MMR			
HIB			
Pneumococcal			

How tall are you _____
How heavy are you _____

PATIENT PROFILING FORM
CONFIDENTIAL

Tick only one box in answer to each question

- **What do you consider to be your ethnic origin?**

Asian	**Other ethnic origin**
Bangladeshi	**Chinese**
Indian	**Other (please specify below)**
Pakistani	
Asian other (please specify below)	
Black or Black British	**White**
African	**British**
Caribbean	**Irish**
Black other (please specify below)	**White other (please specify below)**
Mixed heritage	**Mixed heritage**
White and Asian	**White and Black Caribbean**
White and Black African	**Other mixed heritage pls specify below**

Please specify any other group _____

- **What is your 1st language?**

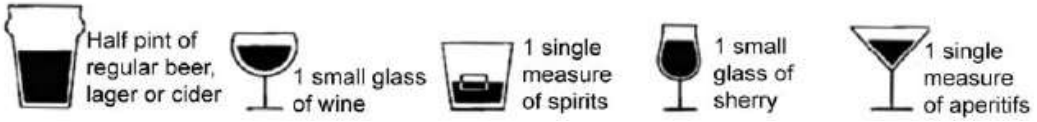
_____

What is your spoken language?_____
Is an interpreter required? _____

AS A TEACHING PRACTICE WE OFTEN NEED PATIENTS TO HELP OUT WITH OUR STUDENTS LEARNING NEEDS. IF YOU ARE HAPPY TO HELP OUT PLEASE TICK HERE □

Name: **DOB:**

- **This is one unit of alcohol…**



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SCORE

The Accessible Information Standard aims to ensure that patients (or their carers) who have a disability or sensory loss can receive, access and understand information, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter.

This applies to patients and their carers who have information and / or communication needs relating to a disability, impairment or sensory loss. It also applies to parents and carers of patients who have such information and / or communication needs, where appropriate.

Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and / or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

• Do you have communication needs? Yes □ No □

• Do you need a format other than standard print? Yes □ No □

• Do you have any special communication requirements? Yes □ No □

• How do you prefer to be contacted? …….

• What is your preferred method of communication? ……

• How would you like us to communicate with you? ……

• Can you explain what support would be helpful? ……

• What is the best way to send you information? ……..

• What communication support could we provide for you? ……..……

…….

Name: ……. Date of birth: …….

If you have a carer do they need communication assistance? Yes □ No □

If 'Yes' what is your Main Carer's name: ……..
Do you consent to the practice contacting your
main carer regarding your care? Yes □ No □

What is the best way to contact them?.....

Signed: …… Date: ……

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