# Magnolia House- Health Database Information
# Please complete all sections

All information provided will be treated as strictly confidential and used only to help your Doctors provide a better service, especially during the inevitable delay that accompanies the request for your detailed medical notes.

| | |
|---|---|
| **Full Name** | **Mr/Mrs/Miss/Ms/Dr/Other** |
| **Address including postcode** | **Home telephone**<br><br>**Mobile telephone*** |
| **Date of birth** | **Marital Status** |
| **Occupation** | **Email address** |
| **Next of kin** | **1st Spoken language** |
| **Relationship** | **2nd Spoken language** |
| **Address** | **Ethnicity** |
| **Tel No** | |
| **Are you a War Veteran?** Yes / No Please delete as appropriate | |
| **Do you have any communication/information needs relating to a disability, impairment of sensory loss?** Yes / No Please delete as appropriate<br><br>If Yes, please complete attached communication preferences form. | |
| **Any Allergies**<br><br>**Height** ft in/ cm<br><br>**Weight** st lb/ kg<br><br>**Smoking habits (please tick which applies)**<br>**Never smoked**<br><br>**Current Smoker ___ per day**<br><br>**Ex-smoker**<br>**(date when stopped)** | **Any family history of serious illness**<br><br>**Family member**<br>**Stroke/CVA**<br><br>**Diabetes**<br><br>**Asthma**<br><br>**Cancer** (GI, Breast, |

Alcohol

***Please Circle most appropriate answer***

1. How often do you have a drink containing alcohol?
- Never - 0
- Monthly or less – 1
- 2 to 4 times a month – 2
- 2 to 3 times a week – 3
- 4 or more times a week – 4

2. How many drinks containing alcohol on a typical day when you are drinking?
- 1 or 2 drinks - 0
- 3 or 4 drinks – 1
- 5 or 6 drinks – 2
- 7 or 8 or 9 drinks – 3
- 10 or more drinks – 4

3. How often do you have 6 or more drinks on one occasion?
- Never – 0

- Less than monthly – 1
- Monthly – 2
- Weekly – 3
- Daily or almost daily – 4

Total Score:

**Carers**

Do you look after anyone who is frail/elderly or infirm for over 2 hours per week? Y / N
Name of Patient _____
Registered at this practice? Y / N
Are you willing for us to keep your name on our database of carers? Y / N
Would you be willing for us to release your name to a third party in order that your needs can be assessed and information provided about benefits. Y / N

…… Signature

**Cervical Smear**

Date

Result

**Adult Immunisation e.g. Travel**
Other: eg Travel- Please specify dates

* If you provide us with your mobile phone number we may use this to send you reminders about your appointments or other health screening information. Please let us know if you do not wish to receive reminders on your mobile.

Do you wish to book appointments, order repeat prescriptions via the web? **YES NO**
**If yes, please ensure that you have completed the Online Patient Access: FAQ and Registration Form (Green form)**