

# MORDEN HILL SURGERY PATIENTS MEDICAL HISTORY FORM

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
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Home Telephone No: \_\_\_\_\_ Mobile No: \_\_\_\_\_  
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Is English your first language?      Yes      No      Email: \_\_\_\_\_

If not what language do you speak? \_\_\_\_\_

Can you give a contact name & telephone number for someone in this country that we could contact in an **Emergency**:

Name: \_\_\_\_\_ Telephone No: \_\_\_\_\_  
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Spouse    Partner    Relative    Friend

Do you help look after a Friend or Relative?      Yes      No      \_\_\_\_\_  
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(Please specify who)

Are you yourself looked after by a Friend or Relative?      Yes      No      \_\_\_\_\_  
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(Please specify who + Tel No.)

If you are between the ages of 5 & 16 years please give the name & address of the school you currently attend?

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## Smoking Status

Current Smoker      Ex-Smoker      Never Smoked

If you are a Current or Ex-Smoker please tick and complete where appropriate below: -

Cigarettes      Cigars      How Many? \_\_\_\_\_      Rolls Own      Pipe      Oz Per Week? \_\_\_\_\_

If Ex-Smoker please tell us when you stopped i.e. Month/Year \_\_\_\_\_  
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**Please tick box if you have ever suffered from any of the following. If you take regular medication you will need to book an appointment for a "New Patient Check" with the Nurse.**

Cancer

Heart Disease / Heart Attack / Angina / Chest Pain

Stroke / Mini Stroke / TIA

Asthma / COPD / Use Inhalers / Emphysema

Raised Blood Pressure

Diabetes

Kidney Problems

Shortness of Breath

Raised Blood Sugar Levels

**If you suffer from depression/anxiety and/or are taking any medication for these or any pain killers please make an appointment to see the GP.**