

Dr Neil Rushton
 Dr Michael Dixon
 Dr David Jenner
 Dr Andrew Smith
 Dr Hilary Harris
 Dr Clare Matthews
 Dr Jeremy Jacob
 Dr James Rowbury
 Dr Fiona Black
 Dr Juliet Nelson



College Surgery Partnership
 College Road
 Cullompton
 Devon
 EX15 1TG
 Telephone (01884) 831300
 Fax (01884) 831313

Welcome to College Surgery Partnership

Please help us by filling in some personal details, **this information is treated in confidence**

Title:..... Surname:..... Forenames:.....

Address:.....Postcode.....

Tel:..... Mobile:..... Email:..... Date of Birth.....

Please indicate how you prefer to be contacted about confidential matters e.g. home telephone /letter / mobile / text/
 other-please specify.....

Nationality please indicate White British etc..... Indicate first language if not English.....

- White British Irish Other White W & B Caribbean W & B African White & Asian
- Other Mixed Indian / British Pakistani / British Other Asian Caribbean African
- Other Black Chinese Nationality withheld Other:.....

Marital Status:..... Next of Kin:.....

Emergency Contact Details:

Name:..... Address:.....Postcode.....

Tel:..... Relationship to you:.....

Children Ages and Names:.....

Occupation (If retired please give previous):.....

Medical history (with *dates* if possible)

Operations	.....	TB / Hepatitis /other serious infection	.....
Other hospital Admissions	.....	Epilepsy	.....
Stroke	.....	Mental health problems	.....
Heart disease	.....	Arthritis	.....
Diabetes	.....	Back pain	.....
High blood pressure	.....	Kidney disease	.....
Asthma	.....	COPD (bronchitis/emphysema)	.....
Cancer	.....	Other	.....

Family history of parent, brother or sister.

	Family member(s)	Age diagnosed (if known)	(age at death)
Diabetes
Heart disease
High Blood Pressure
Stroke
Epilepsy
Cancer (specify)
Glaucoma
Asthma
Other

Please Now Turn Over..... Please Now Turn Over..... Please Now Turn Over.....

Immunisations and vaccinations (dates if known):.....
.....
.....

Allergies: (Please describe reaction)

Drug allergy:..... Other (e.g. pets/pollen).....

Medications:

Please also list any over the counter medications

Please attach **repeat prescription list, or list medications** below:

	Name	Strength	Dose	How Often taken per day/week
1
2
3
4
5
6

If you take regular medication, please ask for a routine appointment with your new doctor

Smoking:

Never
smoked:.....

Current smoker:..... How many a day do you smoke?:..... Would you like help to stop smoking?:.....

Ex-smoker:..... For how Long did you smoke?:..... | How many did you smoke a day?:..... | Date that you stopped smoking:.....

Alcohol:

Units Per Week:..... (1 unit = small glass wine or 1/2 pint normal strength beer or measure of spirits)

Height:..... Weight:.....

Do you have a carer? Y / N

Name, telephone no and any relationship to you:.....

Are you a carer? Y / N

If this is a patient registered with us please give the name and telephone no. of person cared for:
.....

Females only:

Smear results and dates:.....

Mammogram Y / N Last result +Date if Known:.....

Current contraception (please circle)

Combined pill / Progesterone-only "mini-pill" / injection / implant / IUD ("coil") or IUS (Mirena)
-please give date inserted or date of last injection
.....

THANK YOU FOR YOUR TIME, PLEASE HAND IN OR POST TO THE SURGERY

Signed..... **Date**.....