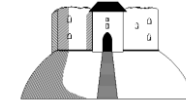


**JORVIK MEDICAL PRACTICE**



**ADULT**  
**QUESTIONNAIRE**

Welcome to Jorvik Medical Practice  
[www.jorvikmedicalpractice.co.uk](http://www.jorvikmedicalpractice.co.uk)

Please complete this form and return with your registration form.

**Name:** .....

**Address:** .....

.....

.....

.....

**Date of Birth :** .....

Telephone Numbers:

Home: .....

Work: .....

Mobile: .....

Information on this form will be transferred to your medical records and will be treated confidentially.

Occupation: .....

***Thank you for joining our practice***

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**Height:**.....

**Weight:**.....

**LIFESTYLE**

**Smoking history**

Current  Amount per week   
Never-smoked   
Ex-smoker   
Cigars/cigarettes/pipe/rolled (please circle)

**Alcohol intake**

How many units per week? .....  
(1 unit = 1 small glass of wine or half a pint of beer/lager)

**Eating habits**

**Good:** (5 a day)   
**Average:** Some fruit/veg   
**Poor:** No fruit/veg mainly fatty foods

**Exercise level**

**Avoid** (never):   
**Light** (walking):   
**Medium** (gym 3 x per week):   
**Heavy** (more than 3 gym per week):

**Allergies:**

.....  
.....

**Significant past medical history:**

.....  
.....

**Next of Kin contact name**

.....  
.....  
Tel No : .....

**Carer:**

Do you have a carer? Yes No  
Are you a carer for someone? Yes No  
(If yes, please give details)

.....

Does your family have any medical problems and if so which member? *Eg, Diabetes, heart disease, deep vein thrombosis, breast cancer.*  
(please give brief details)

.....  
.....  
.....

**ETHNIC MONITORING**  
**QUESTIONNAIRE**

Due to new Department of Health guidelines we are required to request the ethnicity of our new patients. Please tick which ethnic group you feel you belong to:

<u>White:</u>	
<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background
<u>Mixed</u>	
<input type="checkbox"/>	White & Black Caribbean
<input type="checkbox"/>	White & Black African
<input type="checkbox"/>	White & Asian
<input type="checkbox"/>	Any other mixed background
<u>Asian or British Asian</u>	
<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background
<u>Black or Black British</u>	
<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	Any other black background
<u>Any Other Ethnic Group</u>	
<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Any other, please describe
<input type="checkbox"/>	Do not wish to state