

OFFICE USE ONLY
Unit number: _____

Please complete this form in **BLOCK CAPITALS** and return to the reception. Thank you.

Have you attended a G U Medicine clinic before? Yes No
If Yes, when? _____ Where? _____
How many other GU services have you attempted to access with this problem prior to contacting this service? _____

About YOU

<p>Title: _____</p> <p>Forename: _____</p> <p>Surname: _____</p> <p>Date of Birth: _____</p> <p>Address: _____</p> <p>_____</p> <p>Post Code: _____</p> <p>Country of Birth: _____</p>	<p>Telephone numbers where you can be contacted:</p> <p>Home: _____</p> <p>Work: _____</p> <p>Mobile: _____</p> <p>How would you prefer to be contacted?</p> <p>Post <input type="checkbox"/> Mobile 'phone' <input type="checkbox"/></p> <p>Home 'phone' <input type="checkbox"/> Work 'phone' <input type="checkbox"/></p> <p>Can we write to you at your home address?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Can we contact you at your home address?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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Ethnic Origin: *please tick as appropriate*

<p>White</p> <p><input type="checkbox"/> White British</p> <p><input type="checkbox"/> White Irish</p> <p><input type="checkbox"/> Any other White background</p>	<p>Black or Black British</p> <p><input type="checkbox"/> Black British</p> <p><input type="checkbox"/> Black Caribbean</p> <p><input type="checkbox"/> Black African</p> <p><input type="checkbox"/> Any other Black background</p>	<p>Asian or Asian British</p> <p><input type="checkbox"/> Indian</p> <p><input type="checkbox"/> Asian British</p> <p><input type="checkbox"/> Pakistani</p> <p><input type="checkbox"/> Bangladeshi</p> <p><input type="checkbox"/> Any other Asian background</p>	<p>Mixed</p> <p><input type="checkbox"/> Mixed White & Black Caribbean</p> <p><input type="checkbox"/> Mixed White & Black African</p> <p><input type="checkbox"/> Mixed White and Asian</p> <p><input type="checkbox"/> Any othe mixed background</p>	<p>Other Ethnic Groups</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Any other ethnic group</p> <p><input type="checkbox"/> Not stated</p>
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Marital Status: *please tick as appropriate*

Single Co-habiting Married Divorced Widowed

Occupation _____

Are you attending with a partner? Yes No **Partners Name:** _____

YOUR Referral

Please indicate how you were referred or heard about this department: *please tick as appropriate*

GP Family Planning Maternity Partner Friend Self referral Other _____

GP's Name and Address: _____

May we contact your GP with relevant information? Yes No

When did you first try and contact this clinic to be seen or make an appointment? _____

If you waited more than 2 days, was this because *please tick as appropriate*

- You decided to wait until you were free
- There was no appointment / slot available / the clinic was too busy
- You were offered or had an earlier time / appointment but could not attend
- You were advised by staff to wait (for clinical reasons)

In order to speed up your visit and to help us to ensure that you are seen by the right health care professional, please tick one or more of the boxes below.

Please state your age

- I have NO symptoms** (I have nothing wrong and want a sexual health check up)
- I have symptoms (see below)**

<p>MALE</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Irritation inside penis</p> <p><input type="checkbox"/> Discomfort/pain when passing water</p> <p><input type="checkbox"/> Other (pain, lumps, sores rashes)</p> <p>I would like</p> <p><input type="checkbox"/> Blood test only</p>
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<p>FEMALE</p> <p><input type="checkbox"/> Discharge/itching</p> <p><input type="checkbox"/> Other (pain, lumps, sores, rashes)</p> <p>I would like</p> <p><input type="checkbox"/> Emergency Contraception</p> <p><input type="checkbox"/> Blood test only</p>
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I have:

- Had sex with someone who has told me they have an infection
- Been given a contact slip
- Been referred by letter to the clinic
- Been sexually assaulted
- Been paid for sex
- Other (please specify)

I have been asked to:

- Come back for results
- Come back for treatment/vaccination
- Other (please specify)

It is the policy of this department to write to your GP if you have been referred here by letter or if you request us to do so. You are entitled to receive copies of all correspondence with your GP or other hospital colleagues. Please indicate if you wish to receive copies of correspondence by signing the following declaration as appropriate:

'I do/do not wish to receive copies of correspondence with my GP other hospital colleagues'

Signed:

Date:

Information leaflets *Please circle:*

Patient Accepted Patient Refused