

Sexual Health



Have you attended this department before? Yes □ No □         Title:       Forename:       Surname:         Gender:       Male □ Female □ Transgender □ Date of Birth:       Age.         Address:       Postcode         Mobile No:       Home No:         Occupation       Nationality:       Country of Birth:         Marital Status:       Single □ Married □ Civil Partnership □ Separated □ Divorced □ Cohabiting □         Ethnic Origin: White□ Black Caribbean□ Black African □ Black Other □ Indian □ Pakistani □         Bangladeshi □ Chinese □ Other Ethnic Group □         If necessary may we contact you by:       Mobile Text:         Mobile message Yes□ No□         Mobile message Yes□ No□         Mobile message Yes□ No□         If necessary may we contact your GP?         Yes□ No □         Reason for attending the clinic:         Own Accord □ GP's Advice □ Partner's Request □         Other □ (Please specify)         Do you have a Disability?       Yes□ No □         When did you first try to access our services?       Not Known □ Up to 2 working days but less than 2 week b □ Over 2 working days but less than 2 week b □ Over 2 week b □ Over 2 week b □         Do you have a current Problem or Symptom?       Yes □ No □         Have you already consulted your GP with this problem?       Yes □ No □	West Kent Integrated Sexual Health Services Please answer ALL questions, print clearly and tick appropriate boxes. Information provided is confidential.
Gender:       Male       Female       Transgender       Date of Birth:	Have you attended this department before? Yes $\Box$ No $\Box$
Mobile No:       Home No:         Occupation       Nationality:       Country of Birth:         Marital Status:       Single    Married    Civil Partnership    Separated    Divorced    Cohabiting            Ethnic Origin:       White   Black Caribbean   Black African    Black Other    Indian    Pakistani            Bangladeshi    Chinese    Other Ethnic Group          Home Phone:       Yes    No            If necessary may we contact you by:       Mobile Call:       Yes    No          Home Phone:       Yes    No            Mobile Text:       Yes    No          Home Phone:       Yes    No          Home message Yes    No            GP's Name:       Name and Address of surgery:       Mol         If necessary may we contact your GP?       Yes    No          Partner's Request            Other    (Please specify)       No          GP's Advice          Partner's Request            Other    (Please specify)       Yes    No          If yes, please specify	Gender: Male  Female  Transgender  Date of Birth:/
Occupation       Nationality:       Country of Birth:         Marital Status:       Single I Married I Civil Partnership I Separated I Divorced I Cohabiting I         Ethnic Origin:       WhiteI Black Caribbean Black African Black Other I Indian Pakistani I         Bangladeshi I Chinese I Other Ethnic Group I       Home Phone:       Yes No I         If necessary may we contact you by:       Mobile Call:       Yes No I       Home Phone:       Yes No I         Mobile Text:       Yes No I       Home message Yes No I       Mobile message Yes No I       Letter to Address Yes No I         GP's Name:       Name and Address of surgery:       Molie       If necessary may we contact your GP?       Yes No I         Reason for attending the clinic:       Own Accord I GP's Advice I Partner's Request I       Other I (Please specify)       Do you have a Disability?       Yes No I If yes, please specify.         Do you have a Disability?       Yes No I If yes, please specify.       Was this your preferred clinic?       Yes No I       Up to 2 working days I         Wen did you first try to access our services?       Not Known I       Up to 2 working days I       Over 2 weeks I       Over 2 weeks I       Over 2 weeks I       Do I         Do you have a current Problem or Symptom?       Yes No I       Yes No I       Have you already consulted your GP with this problem?       Yes No I       It is the policy of this depa	Postcode
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Ethnic Origin: White Black Caribbean Black African Black Other Indian Pakistani         Bangladeshi Chinese Other Ethnic Group         If necessary may we contact you by: Mobile Call: Yes No         Mobile Text: Yes No         Home Phone: Yes No         Mobile message Yes No         Letter to Address Yes No         GP's Name:         Name and Address of surgery:         If necessary may we contact your GP?         Yes No         Reason for attending the clinic: Own Accord GP's Advice Partner's Request         Other Please specify)         Do you have a Disability?         Yes No         Was this your preferred clinic?         Yes No         Over 2 working days but less than a week         Over 2 weeks D         Do you have a current Problem or Symptom?         Yes No         H 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 departments. Please indicate if you wish to receive copies of correspondence by signing the declaration below         I Do I Do not wish to receive copies of correspondence with my GP or other hospital departments.	Occupation Nationality: Country of Birth:
Bangladeshi □ Chinese □ Other Ethnic Group □       If necessary may we contact you by: Mobile Call: Yes □ No □ Home Phone: Yes □ No □ Mobile Text: Yes □ No □ Letter to Address Yes □ No □         GP's Name:       Name and Address of surgery:         If necessary may we contact your GP?       Yes □ No □         Reason for attending the clinic:       Own Accord □ GP's Advice □ Partner's Request □         Other □ (Please specify)       Output of this department of this problem?         Was this your preferred clinic?       Yes □ No □         When did you first try to access our services?       Not Known □ Up to 2 working days □         Over a week but less than a week □       Over a week but less than a week □         Over 2 working days but less than a week □       Over 2 weeks □         Do you have a current Problem or Symptom?       Yes □ No □         Have you already consulted your GP with this problem?       Yes □ No □         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 departments. Please indicate if you wish to receive copies of correspondence by signing the declaration below         I Do □ I Do not □ wish to receive copies of correspondence with my GP or other hospital departments.	Marital Status: Single  Married  Civil Partnership  Separated  Divorced  Cohabiting
Mobile Text:       Yes □ No□       Home message Yes □ No □         GP's Name:       Name and Address of surgery:       No□         If necessary may we contact your GP?       Yes □ No □         Reason for attending the clinic:       Own Accord □ GP's Advice □ Partner's Request □         Other □ (Please specify)       Output         Do you have a Disability?       Yes □ No □         Was this your preferred clinic?       Yes □ No □         When did you first try to access our services?       Not Known □ Up to 2 working days □ Over 2 working days but less than a week □ Over 2 working days but less than a week □ Over 2 weeks □         Do you have a current Problem or Symptom?       Yes □ No □         It is the policy of this department to write to your GP if you have been referred here by letter or if you 	$\mathbf{v}$
If necessary may we contact your GP?       Yes I No I         Reason for attending the clinic:       Own Accord I GP's Advice I Partner's Request I         Other I (Please specify)       Other I (Please specify)         Do you have a Disability?       Yes No I If yes, please specify         Was this your preferred clinic?       Yes No I If yes, please specify         When did you first try to access our services?       Not Known I Up to 2 working days I Over 2 working days but less than a week I Over a week but less than 2 weeks I Over 2 weeks I         Do you have a current Problem or Symptom?       Yes No I         Have you already consulted your GP with this problem?       Yes No I         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 departments. Please indicate if you wish to receive copies of correspondence by signing the declaration below         I Do I I Do not I wish to receive copies of correspondence with my GP or other hospital departments.	Mobile Text: Yes □ No□ Home message Yes □ No □
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