West Kent Integrated Sexual Health Services

Please answer ALL questions, print clearly and tick appropriate boxes. Information provided is confidential.

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 Call: Yes ☐ No☐ Home Phone: Yes ☐ No ☐
Mobile Text: Yes ☐ No☐ Home message 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 ☐ If yes, please specify…….....

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 a week but less than 2 weeks ☐
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.

Signed…… Date……

Please take this form to reception once completed