**The Rubin Clinic - Integrated Sexual Health**

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

**TITLE:** …. **FIRST NAME:** …….…….. **SURNAME:**……...………. **AGE:**..…… **DATE OF BIRTH:**…….………

**GENDER:** Male 🞏 Female 🞏 Trans F 🞏 Trans M 🞏 **OCCUPATION:**………………………………….………

**ADDRESS:**………………………………………………………………………….........………………………….……………………………………………………………………………………… **POSTCODE**….………………..……….

**CONTACT NUMBER:**………………………………….……..….

**How would you like us to contact you? Phone** Yes/No **Text** Yes/No **Can we leave a voicemail?** Yes/No

**NATIONALITY:**………………………………………. **COUNTRY OF BIRTH:**……………………………………………

**MARITAL STATUS**: Single 🞏 Married 🞏 Civil Partnership 🞏 Separated 🞏 Divorced 🞏 Cohabiting 🞏

**ETHNICITY (please tick box):**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| A White British |  | B White Irish |  | C Any other White |  | D White and Black Caribbean |  |
| E Mixed White and Black |  | F Mixed White and Asian |  | G Other Mixed |  | H Indian |  |
| I Pakistani |  | K Bangladeshi |  | L Any other Asian Background |  | M Black Caribbean |  |
| N Black African |  | O Other Black Background |  | R Chinese |  | S Any other Ethnic Category |  |
| Z Not given |  |  |  |  |  |  |  |

**Do you need any Communication Support?** Yes/No If yes, what support do you need?..........................................

**Do you need written information in another format?** Yes/No If yes what format do you need?…………………………….…

**GP NAME:**……………………… **SURGERY ADDRESS:** …………………………………………………………….

**If necessary may we contact your GP?** Yes 🞏 No 🞏

(We would only contact your GP with your permission or in an emergency)

**REASON FOR ATTENDING THE CLINIC**: Own Accord 🞏 GP’s Advice 🞏 Partner’s Request 🞏

**Do you have a long term disability?** Yes 🞏 No 🞏

**If yes, please state what disability you have?** ………….………………………………………………………….…

**Was this your preferred clinic?** Yes 🞏 No 🞏

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

 Not Known

**When did you first try to access our service with this problem?**

**Do you have a current problem or symptom?** Yes 🞏 No 🞏

**Have you contacted your GP about your 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

Do you wish to receive copies of correspondence with your GP? Yes 🞏 No 🞏

Signed……………………………………………………… Date……………………………………………….

***Please take this form to reception once completed.***

