

Please complete this form in **BLOCK CAPITALS**

NB: Any information you provide will be recorded electronically in the National Sexual Health (NaSH) System and is held in the strictest of confidence. It will NOT be available to ANY healthcare professional body or individual outside of Sexual Health Services without your consent

Have you attended any Sexual Health Services outside Tayside?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes: <ul style="list-style-type: none"> • Please specify where, e.g. Lanarkshire _____ • Do you give your consent for any <i>electronic</i> data recorded by the above NHS Sexual Health Service to be used by us for your treatment in Tayside? Yes <input type="checkbox"/> No <input type="checkbox"/> 		

Who referred you to the clinic today?			
No-one/myself <input type="checkbox"/>	Partner <input type="checkbox"/>	GP - written letter <input type="checkbox"/>	GP - suggested <input type="checkbox"/>
Gynaecology <input type="checkbox"/>	Urology <input type="checkbox"/>	GU Medicine Service <input type="checkbox"/>	Family Planning Service <input type="checkbox"/>
Other Hospital Service <input type="checkbox"/>	Social Work <input type="checkbox"/>	Prison Doctor <input type="checkbox"/>	Armed Forces Doctor <input type="checkbox"/>
Other <input type="checkbox"/>	Please tell us who _____		

Personal Details:		You can choose how much information you give us. However, it is important for us to have <i>at least one way of contacting you</i>	
Title: (tick one)	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/>	Address:	
Surname:			
Forename:			
Date of Birth:	/ /		
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Post Code:	
Date:	/ /		

Telephone Contact Details:										
Home										
Work										
Mobile										

GP Details:	
GP Name:	
Practice Name	
GP Address:	

Contacting your GP:	
Can we contact your GP if necessary?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you test positive for an infection but you are not treated:	
Should you not attend for appropriate treatment we will contact your GP to advise them of this. The GP will take appropriate steps to ensure that you are treated at the earliest opportunity.	
If you definitely <u>DO NOT</u> want us to contact your GP in this case, please tick this box: <input type="checkbox"/> Signature:	

Social Details	
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Co-Habiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/>	Occupation Please state your occupation _____

Please turn form over and complete the other side

Ethnic Origin:	We ask this so we can check everyone gets equal access to our service Which of the following best describes your ethnic origin? (Please choose one)		
A. White Scottish <input type="checkbox"/> Other British <input type="checkbox"/> Irish <input type="checkbox"/> Other white background <input type="checkbox"/>	B. Mixed Background White & Black Caribbean <input type="checkbox"/> White & Black African <input type="checkbox"/> White & Asian <input type="checkbox"/> Other mixed background <input type="checkbox"/>	C. Asian Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian background <input type="checkbox"/>	D. Black Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other black background <input type="checkbox"/>
E. Other <input type="checkbox"/>	F. Do not wish to answer <input type="checkbox"/>	G. Unknown <input type="checkbox"/>	
Do you require a translator?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, for which language?	

Contacting You	We may need to contact you at some point, e.g. to inform you of test results	Alternative Contact Details
How may we contact you? (Please tick all that apply)	Your address? Yes <input type="checkbox"/> No <input type="checkbox"/>	If you don't want us contacting you using any of the details you have provided, is there another address or phone number at which we can contact you? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Your home phone? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Your mobile phone? Yes <input type="checkbox"/> No <input type="checkbox"/>	Care of:
What is your <u>preferred</u> method of contact? (Please tick <u>ONE</u>)	Letter <input type="checkbox"/> Home phone <input type="checkbox"/>	Address:
	Mobile No <input type="checkbox"/>	Post code:

Disability/Health Conditions:	We ask the following to help us get a better idea of where we may need to improve our services for people with a disability or long term condition
Do you have a health condition or disability that has lasted, or is expected to last, 12 months or more? Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>	
If yes, please give us more details:	
Long term illness (e.g. cancer, diabetes, HIV)	<input type="checkbox"/> Details:
Physical Disability (e.g. you use a wheelchair)	<input type="checkbox"/> Details:
Learning Disability (e.g. Down's Syndrome)	<input type="checkbox"/> Details:
Mental Health Condition (e.g. depression, schizophrenia)	<input type="checkbox"/> Details:
Sensory Disability (e.g. you are registered blind or deaf)	<input type="checkbox"/> Details:
Other (Please tell us what)	<input type="checkbox"/> Details:

Other:	
Have you ever fainted when having blood taken?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Further Information
If at any time you would like to know more about how we use your information, you can speak to any member of staff or write to the Lead Clinician for Sexual Health Services using the details below: Dr Jackie Paterson Lead Clinician Sexual Health Services Ninewells Hospital DUNDEE DD1 9SY