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| Woodbridge Practice  Innovation and excellence in healthcare  Name: ………………………………………..D.O.B…………………………  Contact Tel No……………………Can we contact you via text? Yes/No  Height……………………………Weight……………………………………..  Weekly Alcohol intake…………….Do you smoke? Yes/No  Would you like advice on stopping smoking? Yes/No  **Repeat Medications only in this section:**  **Non Repeat items will only be issued if the reason for request**  **is stated. Non repeat items may require a review before issue &**  **may be refused by the GP.**  Item: ………………………………………………………………………………………..  Reason for request: …………………………………………….…………..……………………………..  Item: ………………………………………………………………………………………..  Reason for request: ……………………………………………………………....……………………...  Where do you collect your prescription from? ……………………………………………………………………………………...… |  |