Welcome to Parkhill Medical Practice

For office use only

COMP No		GP / M/Wife		PN / Hca		Day		Date & Time	

REGISTRATION FORMS

Until your full medical records arrive this form acts as a temporary medical record.

Please answer all the questions below in capital letters.

Date / /

Have you been registered at this practice previously? **YES / NO**

Mr/Mrs/Miss/Ms …… Other …… **Surname** ……..….

Forename(s) …… **D.O.B** …….

Address ……

Postcode…… **Tel No** ……

Mobile ……..... Consent to send text messages **YES / NO**
For example, may we send text messages to you for appointment reminders etc.

Email address: ……..…….....
(this will enable you to book appointments and order prescriptions online)

Photo ID / Passport & Address confirmed ☐ **Valid visa seen** ☐

verified by …….

Next of Kin …… Consent to contact Home / Work YES / NO
Relationship …….. Tel no.....

Armed Forces are you a **Veteran** (code #13Ji) YES / NO or a **Reservist** (code #0Z7) YES / NO

Height ...…… **Weight** …….

Are you a smoker? YES / NO If yes how many a day? ……..
Would you like help in quitting? YES / NO

Have you ever smoked? YES / NO
If yes when did you stop? ……. Were you a heavy / moderate / light smoker?

How much alcohol do you consume? …….. units a day ……..units a week
(One unit is ½ pint of beer or a measure of wine or spirit)

Have any of your parents, brothers or sisters developed heart disease or had a stroke at an early age - (males <55 years, females <65 years) YES / NO

Is there a strong family history of:-
Diabetes: YES / NO **Blood pressure problems:** YES / NO **Cancer**: YES / NO
Please detail, and think about talking to your GP about this ……...

Do you have any known allergies? YES / NO
(if yes please give details)…….....……

Do you look after someone? YES / NO **Does someone look after you?** YES / NO
Would you like our Carer Support Worker to contact you? YES / NO

Medical History

Condition	Year of onset	Medication/Drugs	Strength	How often taken

SOME MEDICATION FOR NEW PATIENTS WILL INITIALLY BE CLASSED AS **"ACUTE"** AND WILL **NOT SHOW ON YOUR REPEAT PRESCIPTION FORM** OR WHEN ORDERING ON LINE, BUT CAN STILL BE REQUESTED.

Which pharmacy would you like to use? _____

Do you buy any medication from a pharmacy or health food shop?

_____

SPECIAL NEEDS – HELP US TO HELP YOU

Please tell us about any special needs that you have, so that we can try to accommodate them - for instance, if you cannot use the stairs, we can arrange to see you on the ground floor; if you are profoundly deaf, an interpreter can be arranged.

Do you have any sensory impairment?

Please tick appropriate box	YES	NO
Deafness		
Speech impairment		
Registered blind / partially sighted		
Do you have any specific cultural / religious needs?		
Do you need the services of a translator or interpreter?		
Do you have any phobias you would like us to be aware of? If yes please state:		

If you have already made an **'advance directive' (living will)** , then please make the medical staff aware and bring a copy in when you next see your GP.

Updated Sept 2017

PATIENT ETHNIC ORIGIN / FIRST LANGUAGE QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission of Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

Choose **ONE** section from **A to E** and then tick **ONE** box to indicate your background.

Name: ..... Date of Birth: .....

A White

	British
	Irish
	Any other white background please write below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other white background please write below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other black background please write below

E Chinese or other ethnic group

	White and Black Caribbean
	Any other please write below

Is your first language English? ☐ Yes ☐ No. Please tick box.

If no, what is your first language? **.....**

Please complete this form

Name: ..... D.O.B: .....

Alcohol screen information

Units				
2	1.5	2	1	9
 Pint of regular Beer/Lager/Cider	 Alcopop or Bottle of Beer/Lager	 Glass of wine 1.75ml	 Single measure of spirits	 Bottle of wine

Fast Alcohol Screening Test (FAST)

Scoring system						
Questions	**0**	**1**	**2**	**3**	**4**	**Your score**
How often do you have 8(men) or 6 (women) or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following if your answer above is monthly or less						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/heath worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: A total of 3 or more indicates hazardous or harmful drinking

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.

To do this, it is vital that we hear from people about their experiences, views and ideas for making services better.

By expressing your interest, you will be helping us to plan ways of involving patients that suit you.

It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.

Yes, I am interested in becoming involved in the Practice Patient Participation Group

(Please tick the “Yes” box) ☐ Yes

Patient signature:	
Signature on behalf of the patient	

Date:

Thank you for completing this form

Updated: June 18