Welcome to Parkhill Medical Practice

For office use only

Comp no		GP /PN/HCA		APPT DAY	DATE	TIME

REGISTRATION FORMS - CHILD UNDER 16 YEARS

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** …….

Height ...……... **Weight** …….

Next of Kin ……

Relationship …….. Tel no **.....**

Are you a smoker? YES / NO If yes how many a day? …….

Would you like help in quitting? YES / NO If yes please book a stop smoking appointment

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)…….....……

Are you a young carer. 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 BUT CAN STILL BE REQUESTED.

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, ideally, bring a copy in when you next see your GP.

Updated Dec 2014

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

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