Welcome to Parkhill and Sherwell Valley Medical Practice

For office use only

Comp no		GP / PN HCA/ M/WIFE		APPT 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)**

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 If yes please book a stop smoking appointment
Have you ever smoked? YES / NO
If yes when did you stop? YES / NO 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.

For Nurses to complete

<table>
<tr><td>Blood Pressure</td><td colspan="2"></td></tr>
<tr><td>Urine</td><td>Protein</td><td>Glucose</td></tr>
<tr><td colspan="3">Advice on:

Smoking أ

Alcohol أ

Exercise أ

Diet أ</td></tr>
</table>

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? **..**

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 opportunites 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	

Thank you for completing this form

Today's date:

Updated Jan 2013

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.

NEVER FORGET ANOTHER APPOINTMENT

with FREE text reminders

Register now
for your FREE
appointment reminders

Fill in your details below and hand in to Reception

Name	D.O.B

Postcode

Mobile	Home Telephone

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

PARKHILL
MEDICAL PRACTICE
Parkhill Road
Torquay, TQ1 2AR
Tel: 01803 212489
Fax: 01803 290603

Dr. Simon Murray
Dr. Roger Fearnley
Dr. Louise Anderson
Dr. Gordon Craig
Dr. Anisio Veloso
Dr. Wendy Bonn
Dr. Katherine Kennedy
Dr. Nicola Smales
Maldane Ltd.

SHERWELL VALLEY
MEDICAL PRACTICE
Sherwell Valley Road
Chelston, Torquay, TQ2 6EJ
Tel: 01803 605123
Fax: 01803 690250

Dear Patient,

Welcome to Parkhill and Sherwell Valley Medical Practice.

Please complete the registration form and a new patient questionnaire for each person registering in **BLOCK CAPTIALS**.
(Alcohol questions are for completion by those over 16 only.)

Please return completed forms to reception **AFTER 11am** if possible.
It can be busy earlier in the mornings and you may be asked to wait. A receptionist will need to go through all the forms with you and make you a new patient registration appointment for you.

Please note when registering **ALL** adults **over 16 years of age** will be required to attend and provide **photographic proof of identification (e.g. photo-driving licence, passport or ID card) and one with your current address (e.g. bank statement, utility bill, council tax bill).** Your **National Health Number** is also required and can be obtained from your present surgery.

If you are currently taking any medication, then your check will be with one of our doctors. Please bring your repeat medication slip (or another list of your medication) with you, as this is very helpful for the doctor.

If you are not taking regular medication, then your new patient check will be with a member of our nursing team who will check your blood pressure.
Patients who are aged between 40 and 74 years of age who have no pre-existing medical problems may like to have one of the NHS Health Checks which will test cholesterol and blood sugar as well as blood pressure –please ask the receptionist about these.

As part of the 2015 GP contact all Practices are required to provide their patients with a named GP who will have overall responsibility for the care and support that the Practice provides them. This is the GP whom you are registered with and you will be informed of this at the time of registering. This will not stop you from seeing any of the Doctors in the Practice and you are certainly not restricted to only seeing your named accountable GP.

Thank you.