

Park Side Medical Practice

Park View Centre, Chester Road North, Brownhills, WS8 7JB
Tel No 01543 728748

Dr D Jay

NEW PATIENT QUESTIONNAIRE All Information provided is confidential.

We ask you to **FULLY** complete this form to ensure we have accurate details about your health prior to receiving your medical records from your previous GP.

CHECK LIST

- Fill in Registration Form, Health Questionnaire and Summary Care Record
- Sign the purple registration form
- If applicable - Supply proof of your medication
- If applicable - Supply a copy of your passport and/or proof of address
- Call the surgery in 3 days to check if you have been accepted.
- Once Accepted - Allow a further 2 days for you registration to activate
- Book a New Patient Health Check with the Nurse
(Currently not required due to COVID-19)

Surname:	Forename:	Date of Birth:
Address:		Telephone No(s):
		Opt out of Text messaging (tick box) <input type="checkbox"/>
NHS number (If known):	Main Language Spoken:	
Email Address: (By providing your email address, you are giving consent to receive emails from the practice)		
Ethnicity:		
White/British <input type="checkbox"/> Black/British <input type="checkbox"/> British/Asian <input type="checkbox"/> Mixed British <input type="checkbox"/>		
Other Ethnic Group <input type="checkbox"/> Please State:		

Will you require access to our online appointment / prescription service? YES/ NO

Would you like to receive information or would like to join our Patient Participation Group? YES/NO

Meetings are held on a quarterly basis or you could become a virtual member

Carer: If you have a carer in place please state name address and telephone number.

If you are a carer please state here.

Medical History: Please list any serious illness, operations, ongoing problems & disabilities

Medication: Please list all regular medication including herbal remedies:

Allergies:

Have you ever had a TB vaccination (circle your answer)? YES - Approx When? NO

Height:

Weight:

Do you Smoke? YES NO

If yes, would you like help to quit? YES

How many units of alcohol do you drink per week?

1 unit = ½ pint of beer/lager/cider, 1 small glass of wine, 1 small measure of spirits

Exercise			
Activity Level:	Poor <input type="checkbox"/>	Moderate <input type="checkbox"/>	Fairly Active <input type="checkbox"/>
			Very Active <input type="checkbox"/>

Family History:	
High Blood pressure YES/NO	Glaucoma YES/NO
Heart Disease YES/NO	Thrombosis YES/NO
Stroke YES/NO	Asthma YES/NO
High cholesterol YES/NO	Diabetes YES/NO
Other: (Please state)	
For Women only:	
Number of pregnancies	
Have you ever had a cervical smear? YES / NO If yes date of last smear:	
Have you ever had an abnormal smear: YES / NO	