

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 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):
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** ☐ **Moderate** ☐ **Fairly Active** ☐ **Very Active** ☐

Family History:

High Blood pressure	YES/NO
Heart Disease	YES/NO
Stroke	YES/NO
High cholesterol	YES/NO

Glaucoma	YES/NO
Thrombosis	YES/NO
Asthma	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