**Thorndike Partnership**



**NEW PATIENT REGISTRATION/HEALTH**

**QUESTIONNAIRE**

Dear Patient

Welcome to Thorndike Partnership

To register with the practice please complete this questionnaire as fully as possible. Please bring two forms of identification with you, i.e. household bill (dated within the last 3 months) and driving licence or passport. Once completed please return the questionnaire to the surgery.

Please book your new patient health check appointment with reception. If you are on repeat mediation you will also require an appointment with a doctor. We can book both appointments together if this is more convenient however this may take a little longer to arrange.

If you have a child under 5 years of age please bring your red book with you.

**Personal Details**

Surname: …………………………………….…

Forename(s): ……………..………………… ………………………………….

Address: ………………………………………………………………………………………………………………………………………………

Post Code: ………………………………………………..

Home telephone: ………………….…………..……………………..……

**We use email and text to enhance the care of our patients – Your consent would be appreciated**

Mobile: …………...……………………………………………………………. **Consent to receive text messages: Yes/No**

Email: …………………………………………………………………………….  **Consent to receive emails: Yes/No**

**If patient is under 16 years of age please provide the following:**

School name and address …………………………………………………………………………………………………………..

Is there any social care in place – YES/NO

**First parent/guardian:**

Full name ……………………………………………………………………………………..

Date of birth………………………………………….

Address and post code……………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………

Contact number ……………………………………………………………….

**Second parent/guardian:**

Full name………………………………………………………………………………………

Date of birth ……………………………………….

Address and post code………………………………………………………………………………………………………………….

………………………………………………………………………………………………………………………………………………………

Contact number ……………………………………………………………

**Name of primary carer** ..........................................................................

**Past Medical History**

Please list your medical conditions:

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Prescriptions**

Do you take regular medications: **Yes/No**

**If yes, please list of your regular prescriptions below**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Nominated Pharmacy**

If you have a preferred pharmacy then please state: ………………………………………………………………………………………………………………………………………………………………………

**If you do not state a preference we will send your prescriptions electronically via EPS4**

**Allergies**

……………………………………………………………………………………………………………..

**Immunisations**

If you have details of your immunisations please attach a copy your immunisations record to this form.

**Ethnic Origin**

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.

………………………………………………………………………….

First Language: ………………………………………………. Interpreter Required: **Yes/No**

**Life Style**

**Smoking**

Do you smoke: **Yes/No** If yes, how many cigarettes/ounces of tobacco per day: ………………

Are you an Ex-smoker: **Yes/No**

**Alcohol**

**One drink = 1/2 pint of beer/one small glass of wine/one single measure of spirits**

How many drinks do you have per week: ………………….

**Carers**

Does someone look after you? Or do you need / have anyone who
looks after you or your daily needs as a Carer? **Yes/No**

If *Yes*, would you like them to deal with your health affairs here? **Yes/No**

**The receptionist can help with these arrangements**

Do you look after someone? **Yes/No**

**If yes, please ask the receptionist about Carers support**