CORFTON ROAD SURGERY

NEW PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE - UNDER 16

Family Name: …….. First Name(s): ……

Home Tel. …… Mobile: …… Email address: ……

Date of Birth: …….. Ethnicity: ……..

Weight: …… stones …… pounds **OR** ……kg. Height: ……ft……ins…… **OR** …….. metres.

Next of Kin: Name ……

Contact No ……

Relationship to Patient ……

ALLERGIES

Are you allergic to any medications, substances or foods? ☐ Yes ☐ No

If Yes; please give details:

……

CURRENT MEDICATION

Please give details of any medication which you are currently taking (prescribed or otherwise):

Name of drug: …… Name of drug: ……

Dosage: …… Dosage: ……

Name of drug: …… Name of drug: ……

Dosage: …… Dosage: ……

Name of drug: …… Name of drug: ……

Dosage: …… Dosage: ……

CURRENT MEDICAL HISTORY

Please give details of all current illnesses and conditions

……..

……..

……..

PAST MEDICAL HISTORY
Please give details of any hospital treatment as an in-patient:

……..

……..

NAMED GP
Every patient has a named GP. Your GP is **Dr Alex Fragoyannis.**
This does not affect your choice to see any other doctor at the surgery.

NOMINATED PHARMACY
Which local pharmacy would you like your medication to go to ……..
Please ask reception for advice if you are unsure.

COMMUNICATIONS
Corfton Road Surgery would like to make sure that we give you information in a way that is clear to you.

When we write to you or contact you, please indicate which method you prefer?

☐ No preference ☐ Phone ☐ Email

Do you consent to receiving text messages? ☐ Yes ☐ No

DATA PROTECTION
I understand that this information will be used exclusively in relation to my healthcare.

I agree that my medical information may be shared with other health organisations such as hospitals and walk in centres. ☐ Yes ☐ No

SIGNED ……. **DATE** …….

FOR CHILDREN UNDER 6 YEARS OLD

WE WILL NEED COPIES OF THE CHILDRENS` IMMUNISATION HISTORY

(TRANSLATED TO ENGLISH IF COMING FROM ABROAD OR COPIES OF THEIR RED BOOK)

WITHOUT THIS INFORMATION WE WILL BE UNABLE TO REGISTER ANY CHILDREN UNDER 6