Park View Surgery
24-28 Leicester Road
Loughborough
Leicester
LE11 2AG

NEW PATIENT REQUEST TO JOIN PRACTICE LIST

Please complete and return this questionnaire together with **2** forms of identification.

- medical card *or* passport *or* photo driving license *or* National Identity card

and

- bank/ building society statement *or* utility bill (less than 3 months old) showing home address.

Patient Details:

MR ☐ MRS ☐ MS ☐ MISS ☐ MASTER ☐ MALE ☐ FEMALE ☐ DATE OF REQUEST:……/……/……

SURNAME:…….. PREVIOUS SURNAMES:……

FORENAMES:…….. ……. PREFERRED FIRST NAME:……..

DATE OF BIRTH:… ……/……/…… PLACE OF BIRTH:……

HOME PHONE NUMBER: ……. MOBILE NUMBER:……..

WORK NUMBER: ……. EMAIL ADDRESS:……...

NHS NUMBER (if known):……

CURRENT ADDRESS:……

……. …… POST CODE:…….....

WHITE		**BLACK OR BLACK BRITISH**		**OTHER ETHNIC GROUPS**	
British	☐	Caribbean	☐	Chinese	☐
Irish	☐	African	☐	Any other ethnic group	☐
Any other white background	☐	Any other black background	☐		

MIXED		**ASIAN OR ASIAN BRITISH**		**FIRST LANGUAGE**	
White & Black Caribbean	☐	Indian	☐	British	☐
White & Black African	☐	Pakistani	☐	Other Please state:	
White & Asian	☐	Bangladeshi	☐		
Any other mixed background	☐	Any other Asian background	☐	…….	

HAVE YOU ANY OTHER RELATIVES REGISTERED AT THIS PRACTICE: YES ☐ NO ☐

IF YES, WHAT IS THEIR RELATIONSHIP TO YOU?.....

Please help us trace your previous medical records by providing the following information:

PREVIOUS ADDRESS IN UK:……

PREVIOUS DOCTOR:……

SURGERY ADDRESS:……..

If you are from abroad:

FIRST UK ADDRESS WHERE REGISTERED WITH A GP:……

IF PREVIOUSLY RESIDENT IN UK, DATE OF LEAVING:……

DATE YOU FIRST CAME TO LIVE IN UK:……

If you are returning from the Armed Forces:

ADDRESS BEFORE ENLISTING:…….....

SERVICE OR PERSONAL NUMBER:…….

ENLISTMENT DATE: ……. DISCHARGE DATE: ……..

NHS Organ Donor Registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.

(Please tick as appropriate)

☐Kidneys ☐Heart ☐Liver ☐Corneas ☐Lungs ☐Pancreas ☐Any part of my body

Signature confirming consent to organ donation:……Date …….

NHS Blood Donor Registration

If you would like to give blood please contact 0300 123 23 23 or https://my.blood.co.uk

HEALTH QUESTIONS

1	**What is your smoking history?** *If you are interested in giving up smoking, you can call Resolution on 01509 567766 for free and confidential support from experienced advisors.* *If yes how many*	Never smoked ☐ Ex-smoker ☐ Current smoker ☐
2	**How many units of alcohol do you drink per week?** (1 unit = 1 small glass of wine or ½ pint of beer or 1 small sherry or 1 measure of spirit) (**Please also complete Alcohol Questionnaire attached)**	
3	**Are you a main carer for anyone?** *A carer, without being paid, provides help and support to a friend, neighbour or relative who could not manage otherwise because of frailty, illness or disability.*	Yes☐ No ☐
4	**If so what is your relationship to the person you care for?**	Relative ☐ Neighbor ☐ Friend ☐
5	**Please detail any allergies you have**	
6	**What is your occupation?**	

We sometimes contact our patients via text message please tick this box if you do **NOT** want to be contacted by text message ☐

	NAME OF DRUG	STRENGTH e.g. 300mg	DOSE INSTRUCTIONS How many? How often?	WHO STARTED MEDICATION?	DATE MEDICATION STARTED?
1					
2					
3					
4					
5					

When do you need your next supply of medication?.....
Could you please make an appointment with the GP to set up tour repeat medication before this date.

FAMILY HISTORY
Has any close family member (grandparent, parent, brother, sister, aunt or uncle) had any of, or suffer from, any of the following?

Problem	**Their Relationship to You**	**Their Age When Illness Started**
Heart Attack		
Angina		
Stroke		
Asthma		
Diabetes		

PERSONAL HISTORY
Your full medical record will be sent to us from your last practice in due course. However, in the meantime it is important that we know about the following:

1	Are you diabetic?	Yes/ No
2	Have you ever had a heart attack?	Yes/ No
3	Have you ever had angina?	Yes/ No
4	Have you ever had a Stroke or Transient Ischaemic Attack (TIA) sometimes called a 'mini-stroke?	Yes/ No
5	Do you take medication for an under-active thyroid gland (Hypothyroidism)?	Yes/ No
6	Are you on treatment for blood pressure (Hypertension)?	Yes/ No
7	Do you have Chronic Obstructive Pulmonary Disease (COPD)? This is a disease requiring regular use of inhalers but is not asthma.	Yes/ No
8	Do you take medication for epilepsy?	Yes/ No
9	Do you have asthma?	Yes/ No
10	Have you recently been diagnosed with cancer or any other serious or life threatening disease not mentioned above?	Yes/ No

Did you know?

You can book appointments and order repeat medication through our website.
If you would like to have access to these services please ask at reception and they will activate your account and provide you with log-in details

Alcohol Questionnaire

For the following Questions please circle the answer which best applies to you:
1 drink = ½ pint of beer / 1 glass of wine / 1 single spirit

1: How often do you have a drink containing alcohol?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

2: How many standard drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 or 8	10 or more

3: How often do you have 6 or more standard drinks on one occasion.

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

How we use your data:

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Having this information stored in one place makes it easier for healthcare staff to treat you in an emergency, or when your GP practice is closed.
If you are happy for us to make a Summary Care Record for you please tick the **Yes** box. If you do not want us to make a Summary Care Record for you, please tick **No** – further information on what this means to you can be found at www.nhscarerecords.nhs.uk or by phoning 0300 123 3020.

This part of the application form must be completed or it will delay your registration.

☐ **Yes** ☐ **No**

☐**SIGNATURE OF PATIENT:** …… ……..

☐**SIGNATURE ON BEHALF OF PATIENT**:……**PRINT NAME**:……
