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**Grove Medical Practice**

## Doctor Stephen Patton

Doctor Marie Louise Thornton

Doctor Fionnuala Dickson

**Grove Medical Practice - Patient registration Form**

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# Please note all information submitted is confidential

**Registration at this practice is subject to attending for our registration appointment in order that the Doctors have a full record of your medical & prescription history**

# Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(please underline the name by which you are known)**

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town / Country of BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## 

## Date of birth\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Gender: Male/Female

First Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter needed: Yes / No

Next of Kin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnic origin** White or mixed British □ Irish □ Irish traveller □

White & black Caribbean □ White & black African □

White & Asian □ Caribbean □ African □

Indian or British Indian □ Pakistani or British Pakistani □

Bangladeshi or British Bangladeshi □ Chinese □

Other – please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asylum seeker/ refugee Yes □ No □

**Health promotion:**

Are you a **carer** for an elderly or disabled person? **Yes □ No □** For whom are you a carer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known **allergies**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For female patients only***

Have you ever had a cervical smear? **Yes □ No □** If yes, date of last smear & result \_\_\_\_\_\_\_\_\_\_\_

Have you ever had a mammogram? **Yes □ No □** If yes, date of last mammogram & result \_\_\_\_\_\_\_\_\_\_\_

**Health Questionnaire**

Do you have any of the following **long-term conditions?**

Cancer □ Asthma /COPD □ Learning disability □ Heart disease □

High blood pressure □ Substance misuse □ Dementia □ Diabetes □

Psychiatric problems □ Kidney problems □ Epilepsy □ Thyroid disease□

Please let us know the nature of these problems. This will make your registration appointment more efficient

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Do you have **any other medical problems not already mentioned**? Yes □ No □

Please list these ..……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Do you have any **family history medical information / condition**? Yes □ No □

………………………………………………………………………………………….

………………………………………………………………………………………….

Do you take any **prescribed medications**? Yes □ No □

Please list these with doses ……………………………………………

Please note the practice policy is not to prescribe the following drugs unless you provide evidence from your previous GP- this is in the interests of prescribing safety

* Benzodiazepines: diazepam, temazepam, nitrazepam, lorazepam
* Chlordiazepoxide
* Morphine derivatives: dihydrocodeine, fentanyl, buprenorphine patches, codeine
* Z-drugs: zopiclone, zolpidem

These drugs can be dangerous in long-term use and you would normally need to commit to a reduction strategy

***Please note the practice does not prescribe methadone, diamorphine, temgesic or oral buprenorphine.***

It is practice policy not to replace lost or stolen scripts for the above drugs

I have read & fully understood the practice policy on these drugs and I agree to comply or face removal from the practice list

**Name**

**Signature Date**