Welcome to the Panton Practice

PLEASE BE AWARE BEFORE REGISTERING - WE DO NOT PRESCRIBE ANY BENZODIAZEPINES (new or existing)

Thank you for completing this questionnaire. All information you give is confidential and will be held on your medical records. Please could you:

- Complete **both sides** of this form, writing clearly and in **BLOCK CAPITALS**
- Take your blood pressure using the machine in the foyer and attach the ticket to this form

Your name:			
Your date of birth:			
Your email address:			
We may occasionally communicate with you by SMS or email mainly to remind you of appointments or health messages. We will not pass your email address or phone number to any non-NHS organisation. Tick here if you do **NOT** wish to be contacted by email or SMS. ☐			
Who should we contact in an emergency?			
Name:			
Their relationship to you:		Their date of birth:	
Their telephone number:		* Are they also registered with us ?	**YES / NO**

Summary Care Record – Please read attached information sheet before answering the following question.

SCR Consent *(Please select one box only)*	☐ Express consent for medication, allergies and adverse reactions only
	☐ Express consent for medication, allergies, adverse reactions and additional information
	☐ Express dissent – Does not want a Summary Care Record ***(please also sign separate disclaimer for this)***
Signed:	

Ethnicity

What is your country of birth? _____ What is your first language? _____

How would you describe your Ethnicity _____

Do you work?

☐ Employed ☐ Self-employed ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired

What is your current occupation? _____

Social Habits

***Smoking*:** please tick the box that applies to you

☐ I am a SMOKER How many per day? _____

☐ I am an EX-SMOKER When did you stop smoking? _____

☐ I have NEVER SMOKED

***Alcohol*:** How often do you have a drink that contains alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking?

One standard drink is: 1 single measure of spirits, 1 small glass of wine, half a pint of beer, lager or cider. A bottle of wine is 9 units

☐ 1 - 2 ☐ 3 – 4 ☐ 5 - 6 ☐ 7 - 9 ☐ 10+

How often do you have 6 or more standard drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Nominated Pharmacy

Which Pharmacy do you normally use? _____

Would you like your prescriptions to be sent to them electronically? ☐ Yes ☐ No You will need to register with the selected pharmacy for this service.

ALTERNATIVELY:-

Would you like to collect your prescriptions from the Surgery yourself? ☐ Yes ☐ No

Which Surgery would you like to collect your prescriptions from? ☐ Gervis Road ☐ St Leonard's Road

Measurements

HEIGHT, WEIGHT AND BLOOD PRESSURE	**** PLEASE USE THE MACHINE IN THE FOYER AND ATTACH PRINTOUT***

Exercise Do you take exercise that lasts for at least 20 minutes per session? ☐ Yes ☐ No

If Yes, how many times a week? ☐ 1 ☐ 2 ☐ 3+

Carer/Housebound information

Do you have a Carer? ☐ Yes Name and contact no. of Carer: _____

Are you a Carer? ☐ Yes Name of person you care for: _____

Are you housebound? ☐ Yes

Personal medical history

Please list with dates any ***significant*** (chronic or acute) current or past illnesses, operations and especially **allergies**

ILLNESS, OPERATION OR ALLERGY	Date	ILLNESS, OPERATION OR ALLERGY	Date

DO YOU TAKE ANY REGULAR MEDICATION **YES / NO**

Family History

Have any of your close family (parents/brother/sister) had any of these illnesses or conditions?

		Details, for example Father, Mother, Sister
☐	Raised cholesterol	
☐	Stroke	
☐	Heart disease before the age of 60	
☐	Heart disease after the age of 60	
☐	Asthma	
☐	Cancer	
☐	Diabetes	

Women only

Are you pregnant? ☐ Yes ☐ No If Yes, when is your baby due? _____

What type of contraception do you use, if any? _____

Do you have any information or communication needs we should know about? ☐ Yes ☐ No

For example - Do you need documents in large print, a sign language interpreter, use of our hearing aid loop ? Please let us know how we can help you.

THANK YOU FOR YOUR TIME AND YOUR HELP IN COMPLETING THIS QUESTIONNAIRE

Issuing of the registration documents does not guarantee registration with this Practice

For office use only: **ENTITLED TO SECONDARY CARE ? :** ☐ Yes ☐ No **PATIENT ADVISED ? :** ☐ Yes ☐ No

Proof of ID seen: ☐ Yes ☐ No **European Health Insurance card (EHIC – S1or S2)** ☐ Yes ☐ No _____

Type: _____ Initials/Date: _____

Proof of address seen (for example Utility Bill): ☐ Yes ☐ No

Type: _____ Initials/Date: _____