GROVE HOUSE PRACTICE

NEW PATIENT REGISTRATION - HEALTH QUESTIONNAIRE

This information will help make an initial assessment of your health which will help with your future treatment. You may be invited to attend a new patient health assessment.

Please complete each row and circle the relevant choice.

1. Personal Details			
Surname			
Forename(s)			
Date of Birth		Marital Status	
Home Telephone No.		Mobile Telephone No.	
Email Address			
Ethnic Origin	White / Mixed / Asian or Asian British / Black or Black British / Chinese / Other		
Main/First Spoken Language		Interpreter needed?	Yes / No
Have you previously been registered here?		Yes / No	
Summary Care Record Preference *(please see our patient info leaflet: New Patients: How to Register)*		I agree / do not want	

2. Medical History ***(please continue overleaf if necessary)***	
List of any Current Medication *(name of drug and dosage for each)*	
Nominate Pharmacy for Electronic Prescriptions	Wise (Jenson Court) / Boots (Halton Lea) / Asda (Halton Lea) / Peak (High Street) / Wise (Halton Brook) / Boots (High Street) / Lloyds (Old Town) / Wise (Windmill Hill) / Well (Grangeway) / Peak (Church Street)
Details of any Recent Hospital Attendances	
List of any Current Health Conditions *(eg asthma, stroke, cancer, COPD, atrial fibrillation, heart disease, epilepsy, diabetes, kidney disease)*	
List of any Known Allergies	

3. Lifestyle			
Height		Weight	
Are you?	Current Smoker • If yes, how many a day	Ex-Smoker	Never Smoked
Do you take Regular Exercise?	Yes / No • If yes, what do you do and how often?		
Do you Drink Alcohol?	Yes / No • If yes, how much in an average week?		
Do you provide care for someone aged 18 or over?	Yes / No		

4. Female adult patients only
Approx date of last Cervical Smear? / / last Mammogram? / /

Application For Online Services Access (Form A) June 2017

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

I understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature	Date

Any additional Information

For practice use only
ACCESS ONLINE

NHS Number		
Practice sign up letter and leaflet given to patient ☐		
Identity verified by (initials)	Date	Method Photo ID and proof of residence ☐ Vouching ☐ Vouching with information in record ☐

Type of Review at Initial Health Assessment?

APPT WITH: GP PN CP HCA NO Date ________________ Name____________________