

GROSVENOR MEDICAL CENTRE - NEW PATIENT QUESTIONNAIRE

SURNAME _____ [previous surname] _____

FIRST NAME _____

Date of Birth ____ / ____ / ____ Marital Status _____

Address _____

Post Code _____ Occupation _____

Telephone No. _____

<u>ETHNIC ORIGIN</u>				
White	British <input type="checkbox"/>	Irish <input type="checkbox"/>	Other <input type="checkbox"/>	
Mixed	White/Black Caribbean <input type="checkbox"/>	White/Asian <input type="checkbox"/>	White/Black African <input type="checkbox"/>	Other <input type="checkbox"/>
Asian or Asian British	Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other <input type="checkbox"/>
Black or Black British	Caribbean <input type="checkbox"/>	African <input type="checkbox"/>	Other <input type="checkbox"/>	
other ethnic categories	Chinese <input type="checkbox"/>	Other <input type="checkbox"/>		

MAIN LANGUAGE SPOKEN _____

Medical Details

Past medical history (please list any operations or procedures with dates)

Other serious illness E.g., High Blood Pressure, Asthma, Diabetes etc and dates if known

Allergies _____

Current Medication _____

PLEASE TURN OVER



Patient's details

Please complete in **BLOCK CAPITALS** and tick as appropriate

Mr
 Mrs
 Miss
 Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

Male
 Female

Town and country of birth

Home address

Postcode

Telephone number

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

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your 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 Personnel number

Enlistment date

If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

I live more than 1 mile in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

Signature of Patient

Signature on behalf of patient

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

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register

Date

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services
 For the provision of contraceptive services
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.
 Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name

Date

Practice Stamp