**North Parade Medical Centre  
New Patient Summary**

Please complete this form fully and sign before returning to the practice with supporting documentation. **We will ask you to retain all forms until all the information has been provided.**

**Section A – Patient Details**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Previous surname (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: (Mr/Mrs/Miss/Ms): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male: Female:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_

Telephone Number:

(Mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin: (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section B**

**Current Medication** (If YES provide a printout summary from previous GP)

Are you currently on any regular medication? YES No

**\* The surgery is not currently accepting shared care from the private sector for ADHD medication\***

**Known Allergies** (If YES please also list allergies below)

Do you suffer from any known allergies? YES No

|  |
| --- |
|  |

**Interpreter Service for Sign Language**

Do you require an interpreter service for sign language? YES No

If yes, please provide details of interpreter service/person and contact details.

Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tele/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Carer Status:**

Are you a Carer? Yes | No (If yes we require you to complete a carer’s form)

**Section C**

**Consent for Text Messaging**

Are you happy for the practice to communicate with you by text message: Yes | No

**Past Medical History (i.e Operations, Illnesses)**

|  |
| --- |
|  |

**Family History**   
Please circle where appropriate & stated relationship & age

|  |  |  |  |
| --- | --- | --- | --- |
| Heart attack/Angina | Yes / No | *Relation:* | *Age of onset:* |
| Stroke | Yes / No | *Relation:* | *Age of onset:* |
| High Blood Pressure | Yes / No | *Relation:* | *Age of onset:* |
| Diabetes | Yes / No | *Relation:* | *Age of onset:* |
| Glaucoma | Yes / No | *Relation:* | *Age of onset:* |
| Asthma | Yes / No | *Relation:* | *Age of onset:* |

**Health Promotion**

|  |  |  |
| --- | --- | --- |
| Never Smoked | Ex-Smoker | Current Smoker - No./day |

Do you drink alcohol? Yes / No Units/week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(1 Pint Beer = 2 Units, 1 Glass Wine = 1 Unit, 1 Measure Spirits = 1 ½ Units)

Do you take regular exercise? (times/week): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recordings (Home or at GP Surgery)**

Date of measurements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnic Origin** (Please circle where appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| White | Black African | Indian | Bangladeshi |
| Black Caribbean | Black Other Mixed | Pakistani | Chinese |
| Other (please stated): | | | |
| I do not wish my ethnic origin recorded | | | |

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is the Patient living in a:** Nursing Home / Residential Home

**Date of last Cervical Smear: (as applicable only)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section D**

**Hospital Outpatients**

Details of any hospital outpatients you are currently attending:

|  |
| --- |
|  |
|  |

If you are currently attending any outpatient appointments please inform them of your new GP and if you have a new address.   
**Please be aware failure to do so can include but not limited to delayed and/or missed appointments.**

**Previous GP**

Name & Address of Last Doctor:

|  |
| --- |
|  |

Reason for Changing Doctor:

|  |
| --- |
|  |

**Section E – Foreign Nationals Only**

Is English your first language? YES | NO

Languages Spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Starting with most fluent)

Would you benefit from an Interpreter Service, if so which language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin in Country of Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact in Northern Ireland (if not abroad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section F – Asylum Seekers Only**

If you are an asylum seeker please tick:

If you have a case worker please provide contact details

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section F – Patient Signature**

I can confirm that the information I have provide is true and accurate.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At this point please check the cover page again for any required documents, then proceed to complete the remaining pages of the registration pack.