DATE:		Practice ID:	

MODYRVALE MEDICAL CENTRE

PATIENT QUESTIONNAIRE

Patients over 18 registering with the Practice will require an appointment with our Practice Nurse. This will be arranged by one of our reception staff. To assist us in processing your registration, **please arrive 10 minutes prior to your appointment time**.

Please note that failure to attend, or late arrival, without advance notification will result in you not being able to register with the Practice. Please initial this box to confirm that you have read/understood this: ☐

Please bring photographic ID and a urine sample to your appointment.

HAVE YOU PREVIOUSLY BEEN REGISTERED WITH THIS GP PRACTICE?	YES ☐	NO ☐	If yes, why did you leave?

NAME:	DATE OF BIRTH:
ADDRESS:	HOME TEL NO:
	MOBILE TEL NO:
	OCCUPATION:
NEXT OF KIN:	THEIR CONTACT TEL NO:

ETHNIC ORIGIN	WHITE ☐	BLACK ☐	ASIAN ☐	CHINESE ☐	MIXED ☐	OTHER ☐

MARITAL STATUS	MARRIED ☐	SINGLE ☐	WIDOWED ☐	DIVORCED ☐

Please answer/provide details on the following:

1. Who lives at home with you?
2. Current illnesses:
3. Current medication:
4. Past illnesses:
5. Hospital admissions/ previous operations:
6. Allergies:

7. Do you smoke?	YES ☐	Never smoked ☐	Ex-smoker ☐	If yes how many a day?
8. Do you drink alcohol	YES ☐	NO ☐	If yes how many units per week?	
9. Do you take recreational drugs?	YES ☐	NO ☐	If yes please provide details.	
10. Reason for applying for registration with this Practice.				

Continued, please turn over.....

Family medical history: Diabetes ☐ Heart disease ☐

Hypertension ☐ Other .....

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Ladies: Number of children:.....

Date of last smear: ..... Due Smear: .....

Details of children under 5

1 Name..... Date of Birth .....

Immunisations: 1st ☐ Pre-school booster: ☐

2nd ☐

3rd ☐

2 Name..... Date of Birth .....

Immunisations: 1st ☐ Pre-school booster: ☐

2nd ☐

3rd ☐

Where you live:

I confirm that my current address is within the Practice boundary.

(please note we reserve the right to ask you to register with a GP closer to your home if we subsequently identify your home address as being outwith the Practice Boundary)

YES ☐

NO ☐

DON'T KNOW ☐

So that you don't miss out on important information:

The Practice uses a text messaging service to contact patients, e.g. for appointment reminders, flu vaccination, online services, general/health messages etc. Please complete the section below if you are happy to be contacted by text message.

YES, I agree to being contacted by text message and will keep my registered contact details up to date with the Practice.

Signed: _____ Print: _____ Date: _____

To be completed by Nurse:

Weight..... Height .....

Last tetanus vaccine ..... Last polio vaccine .....

Risk factors .....

Please also complete NHS Application to Register permanently with a General Medical Practice form ref: GMSGPR001 which is also available at reception.

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