NEW PATIENT REGISTRATION AND PROCEDURES FORM

Welcome to Cheriton and Teign Valley Practice

As a new patient to our Practice, we would like to extend an invitation to you and your family to attend a New Patient Assessment sometime within 28 days of registering with us. This will be conducted by one of our Practice Nurses and it enables us to obtain an up to date medical history from you, and to introduce ourselves and tell you about the Surgery and the facilities offered.

May we encourage you to attend this appointment as your medical notes can take some time to arrive from your previous Doctor, and this will give us current information about the state of your health when and if you should need us.

Please make an appointment at reception or ring us on 01647 24272 and ask for a New Patient Assessment with the Practise Nurse and we shall endeavour to find a convenient time for you to attend.

Please bring with you:-

1. A specimen of your urine (in a clean jar)
2. Any vaccination records you may have

Please complete both sides of this form as best you can and sign this form and the other forms you have been given.

SURNAME …… **FORENAMES** ……

DATE OF BIRTH …… **TELEPHONE NO.** ……

EMAIL ADDRESS …… **MOBILE NO.** ……

MARRIED / SINGLE / DIVORCED / SEPARATED / WIDOWED

NEXT OF KIN First & Surname …….

Tel No. …… **Mobile No.** …… **Relationship** ……

Address if different from above ……

If you are elderly, or have a chronic illness, do you have a Carer **Yes/No**
If so please give name, address, telephone number and date of birth of carer

…… ……

……..

Are you a carer for somebody? If so whom ……
Do you or they receive help from Social Services **Yes/No**
Do you or they need help with Social Services **Yes/No**

Text messaging – opt out YES

SIGNED ……

ALLERGIES:

CURRENT MEDICAL PROBLEMS:

CURRENT MEDICATION:

Do you smoke, if so how many? Please put none if a non smoker……. If an ex-smoker please put date of stopping …….	Alcohol (Units per week) Exercise Reg / Occ /Impossible	Height Weight

Are you aware of any of your relatives having heart disease of cancer? If so please record relative with approximate date of onset.

	RELATIVE	AGE OF ONSET
HEART PROBLEMS		
HIGH CHOLESTEROL (over 7.5)		
RAISED BLOOD PRESSURE		
GLAUCOMA		
DIABETES		
ASTHMA		