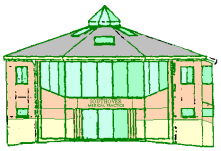
Dr I R TRESIDDER
Dr D G GREENWELL
Dr J M RIDGE
Dr C HANCOCK
Dr D JEFFERY
Dr D SCOTT

Southover Medical Practice
Bronshill Road
Torquay
Devon
TQ1 3HD



Tel: 01803 327100
Enquires.southover@nhs.net

NEW PATIENT QUESTIONNAIRE

Dear New Patient,

Welcome to our Surgery.

Here at Southover Medical Practice you will be registered with one of our Partners.

Dr Tresidder, Dr Greenwell, Dr Ridge and Dr Hancock.

Any current health problems can be discussed with your Doctor by either going online and filling in an e-consult form, where a GP will get back to you by the end of the following working day, or we have a book on the day system as well as a limited amount of pre-bookable appointments. Please also ask about Online Services which will let you book appointments online.

You can download the NHS/Patient Access app on your smartphone, tablet or computer which will enable you to order your medication and view parts of your medical records. Prescription requests are not taken over the phone and an appointment is also unnecessary for repeat prescriptions. A request can be made in several ways such as; NHS app, Patient Access, via email to prescriptions.southover@nhs.net or in writing and placed in the letterbox. All medication will be sent electronically to a chemist of your choice, please select a pharmacy in the questionnaire.

All patients registering with the Practice who have a chronic condition will be sent a letter to book an appointment for an Annual Check-up in their birthday month. A urine sample will be requested at this examination for which a specimen bottle may be obtained from reception. We also have a surgery pod where you will need to record your height, weight and blood pressure - Please hand these results back to reception.

Please fill in the questionnaire overleaf and bring it in with you when you return your registration forms with two forms of ID, one being a photo i.e. passport, driver's license or buss pass and something with your current name and address on such as a utility bill or statement.

Yours faithfully

Dr's Tresidder, Greenwell, Ridge, Hancock Jeffery & Scott

Southover Medical Practice

New Patient Registration Form

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

<table>
<tr><td colspan="3">Full Name:</td><td colspan="3">Telephone Number:</td></tr>
<tr><td colspan="3">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="3">Work Number</td></tr>
<tr><td colspan="3">Address and Postcode</td><td colspan="3">Mobile Number:</td></tr>
<tr><td colspan="6">E-mail Address:</td></tr>
<tr><td colspan="6">Next of Kin:</td></tr>
<tr><td colspan="6">Next of Kin Contact Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Previous / Mother’s surname if different:</td><td colspan="2">Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td>Gender:</td><td>Male:</td><td colspan="2">Female:</td><td>Other residents of your home:</td></tr>
<tr><td colspan="6">Occupation:</td></tr>
<tr><td colspan="6">Names & Ages of Children</td></tr>
<tr><td colspan="3">Previous Address</td><td colspan="3">Previous Postcode:</td></tr>
<tr><td colspan="6">Previous Doctor Telephone No.</td></tr>
<tr><td colspan="3">Previous Doctor Name & Address:</td><td colspan="3">NHS Number (if known)</td></tr>
<tr><td colspan="6">If applicable, date you
first came to live in Britain:</td></tr>
</table>

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**

Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**

Your Ethnic Origin: **(select one)**	**White (UK)** **9i0**	**White (Irish)** 9i1%	**White (Other)** 9i2%
Caribbean **9i3**	**African** **9i4**	**Asian 9i5**	**Other Mixed Background 9i6%**
Indian / **Brit Indian 9i7**	**Pakistani /** **Brit Pakistani 9i8**	**Bangladeshi / Brit Bangladeshi 9i9**	**Other Asian Background 9iA%**
Other Black Background	**Chinese** **9iE**	**Other** **9iF%**	**Ethnic Category not stated 9iG**

Your main or 1st language Spoken / Understood **(select one)**	**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**

Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other:** **(Please Specify)**

Prescriptions, Internet Access to Booking Appointments and Viewing your Medical Records By nominating a Pharmacy your Prescriptions can be sent direct electronically.

Please indicate with a tick your Pharmacy of choice
Day Lewis Pharmacy at Southover
Day Lewis Pharmacy Ilsham Rd
Walnut Road
Pembroke
Manor
Well Pharmacy
Boots Pharmacy Tor Hill Road
8 Fore Street
27 Fore Street
The Strand
Wren Park
Union Street
Superdrug Union Street
Babbacombe Pharmacy Reddenhill Road
Torwood Pharmacy Torwood Street
Watcombe Pharmacy Fore Street, Barton
Dowricks Chemist Chelston Hall
Manor Pharmacy The Health Centre
Sherwell Valley Pharmacy Sherwell Valley Road
Hele Pharmacy Hele Road
Care4u Pharmacy Croft Road
Sainsbury's The Willows
Other

You can book appointments to see a Doctor, order prescriptions and look at parts of your medical records via the internet or smartphone using the free NHS or Patient Access apps.

Provided that you have given us your email address, we can set you up for this free service and will produce a letter with your registration details for you to collect from reception in the next few days.

If you would like this facility, please tick the box ☐ www.southovermedicalpractice.co.uk

If returning from Armed Forces:		**Your Service or Personnel Number**		**Your Enlistment Date**	
Your height:	**Feet / inches**	**cm**	**Your weight:**	**Stones / lbs.**	**kg**
Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?		**No. times per week**		**Type(s) of exercise:**	
Your Medical Background:					
What illnesses have you had & When?					
What operations have you had, where and when?					
Do you have any medical problems at present?					
Please list any tablets, medicines or other treatments you are currently taking: **(incl. dose + frequency)**					
Are you able to administer your own medicines?		**Yes**		**No – please detail specific issues (e.g. swallowing, opening containers)**	

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**

Breast Cancer	**High Blood Pressure**	**Asthma**	**Stroke**
Thyroid Disorder		**Any other important Family Illness?**	

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**

Whooping Cough	**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**

Specific Needs: **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:**
Please state any Sensory Impairment you have **(i.e. Speech, Hearing, Sight):**
Are you an 'Assistance Dog' User?
Please state any Physical disabilities you have:
Please state any Mental disabilities you have:
Please state any requirements you have to be able to access the Practice premises
Please state any Religious or Cultural needs:
Do you require the help of a Translator / Interpreter?
Please state any specific nutritional requirements you have:
Please state any allergies and sensitivities you have:
Please state any phobias you have:

If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**
Signed: Date:	

Do you have a "Living Will" **(a statement explaining what medical treatment you would not want in the future)?**	**Yes / No**	***If "Yes",*** ***can you please bring a written copy of it*** ***to your New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**

Women only:

When was your last smear done?	**Date**	**Was this at your** **GP's Surgery?**	**Yes**	**NO**
What was the result **of the smear?**				

Date of last mammogram **(if applicable):**	**Date**	**Method of contraception (if used):**
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?	**Yes**	**NO**

Summary Care Records.

The NHS are changing the way your health information is stored and managed.

The NHS Enhanced Summary Care record is an electronic record of important information about your health.

It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.

To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.

By expressing your interest, you will be helping us to plan ways of involving patients that suit you.

It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.

If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**
Patient Signature:	**Signature on behalf of Patient:**

Fast Alcohol Screening Test (FAST)

For the following questions please circle the answer which best applies.

1 drink = ½ pint beer or 1 glass of wine or 1 single spirits

1. MEN: How often do you have EIGHT or more drinks on one occasion?

WOMEN: How often do you have SIX or more drinks on one occasion?

Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

Never	Less than Monthly	Monthly	Weekly	Daily or almost daily

4. In the last year has a relative or friend, or a Doctor or other Health Worker been concerned about your drinking or suggested you cut down?

No	Yes, on one occasion	Yes, on more than one occasion

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.southovermedicalpractice.co.uk