Dounby Surgery

Dounby Orkney KW17 2HH

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Partners
Dr H Thomas
Dr M Thomas
Dr R Palmer
Dr A Filipek
Salaried GPs
Dr S Gills

Patient Registration Questionnaire

Any information given will be treated as strictly confidential.

About You

Title :......... Surname :................................. Forename(s) :...

Preferred calling name :.............................. Date of Birth :...................... Gender :.......................

NHS Number:... CHI Number :...

Contact Information

Address :...

Postcode :.. Email :...

Mobile :.. Telephone :..

Marital Status

Marital Status :..

Next of Kin (For Emergency Contact)

Surname :..Forename(s) :...

Relationship to you :..

Mobile :.. Telephone :..

Ethnicity

We would be grateful if you could provide the following information.
I would describe my ethnicity as:

- ☐ (Asian or Asian British) Bangladesh
- ☐ (Asian or Asian British) Indian
- ☐ (Asian or Asian British) Other background
- ☐ (Asian or Asian British) Pakistani
- ☐ (Black or Black British) African
- ☐ (Black or Black British) Caribbean
- ☐ (Black or Black British) Other background
- ☐ (Mixed) Other background
- ☐ (Mixed) White and Asian
- ☐ (Mixed) White and Black African
- ☐ (Mixed) White and Black Caribbean
- ☐ (Other) Any other
- ☐ (Other) Chinese
- ☐ (White) British
- ☐ (White) Irish
- ☐ (White) Other background
- ☐ (White) Scottish
- ☐ Not stated / Decline to comment

Other Ethnic Group :...
Other Ethnic Group ....

Have you ever been seen at Dounby Surgery before? **Yes / No**

If Yes, was it under a different surname? **Yes / No** Previous Surname :..

Occupation

Current Occupation :..

Place of Birth

In which Country and City were you born? :...

If you are from abroad, what date did you come to the UK? :...

Previous Information

Previous GP Practice Name :...

Address :..

Have you ever been seen at this Surgery before? **Yes / No**

If Yes, was it was under a different surname? **Yes / No**

Carer Status

Are you yourself an unpaid carer? **Yes / No**

If Yes, please contact Admin to request an Unpaid Carers Declaration Form

Do you have an unpaid carer? **Yes / No**

If Yes, please provide their :

Name :..Relationship to you :...

Resuscitation Wishes & Power of Attorney

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes / No**

Does anybody hold Lasting Power of Attorney for Health and Welfare for you? **Yes / No**

If Yes, please supply details of who holds this :..

Please supply a copy of this form for your medical notes

Disabilities / Accessible Information Standards

At the Practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs? **Yes / No**

If yes, please state your needs :..

Do you need an interpreter? Yes / No

Are you blind / partially sighted? **Blind / Partially sighted**

Do you have significant problems with your hearing? **Deafness / Hearing difficulty**

Do you have significant mobility iss ues? **Yes / No** Are you housebound? **Yes / No**

Family History & Past Medical History

Do you have any medical conditions? (eg. Angina, Asthma, Diabetes, Epilepsy etc.) **Yes / No**

If Yes, please specify :..

....

....

Do you have any significant medical conditions within your family? **Yes / No**

If Yes, please specify :..

....

....

Have you had any significant operations / procedures? (eg. Heart bypass etc.) **Yes / No**

If Yes, please specify :..

....

Allergies

Do you have any allergies to drugs or food? Yes / No

If Yes, please specify :..

....

Current Medications

Please provide a list of any current repeat medications you take :

Medication :...Strength....................Dose :................................

Medication :...Strength....................Dose :................................

Medication :...Strength....................Dose :................................

Medication :...Strength....................Dose :................................

Medication :...Strength....................Dose :................................

Medication :...Strength....................Dose :................................

Medication :...Strength....................Dose :................................

Please use overleaf for any further medications.

Preferred Pharmacy for collection

Please circle one - **Dounby Pharmacy / WHBS Stromness / WHBS Kirkwall / Boots Kirkwall**

Consent

I consent that the information given is true to the best of my knowledge.

Signed (Patient / Parent/Guardian) :..

Print Name :.. Date :..............................