DR S E DAVIES * DR B G ROBINSON * DR N REES * Dr R HUGHES
PONTPRENNAU MEDICAL CENTRE

All new patients joining this Practice are requested to present in person and to provide proof of residency within the area.

REGISTRATION QUESTIONAIRE – 16+

In order to provide you with good medical care, please complete the following questionnaire.

ALL THE INFORMATION ON IT IS COMPLETELY CONFIDENTIAL

Please be as accurate as you can with all the answers.

Have you previously been registered at either The Pontprennau Medical Centre?

Yes □ **No** □

Are you on any repeat medication?

Yes □ **No** □

If yes, please book an appointment for a health check with our practice pharmacist or healthcare assistant.

It is the custom of this Practice that all new patients are given a health check as part of their registration if they are on repeat medication. If you are on repeat medication please supply the practice with a copy of your repeat slip, which can be obtained from your previous surgery. If you do not provide the practice with a copy of your repeat slip there may be a delay in your medication being issued.

PERSONAL DETAILS

SURNAME _____

FORENAMES _____

D.O.B. _____

ADDRESS _____

_____

TELEPHONE NO's Home Mobile Work

EMAIL _____

MARITAL STATUS SINGLE/MARRIED/WIDOWED/DIVORCED/SEPARATED

MILITARY VETERAN YES/NO

We have an electronic method of contact available for patients. Do you consent to the practice contacting you by text message or email for appointment reminders, prescription and sick note updates or anything relevant to your healthcare?

YES/NO (Please delete as appropriate)

OTHERS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP

Next of Kin & contact number:

_____
_____
_____
_____

MEDICAL HISTORY

Do you have any physical disabilities that we should be made aware of?

_____

_____

_____

Have you suffered from any of the following illnesses?

	Yes/No	If yes, please give details
DIABETES		
HEART DISEASE		
HIGH BLOOD PRESSURE		
ASTHMA		
COPD		
EPILEPSY		
STROKE		
THYROID PROBLEMS		
OTHER SERIOUS ILLNESS		
Have you ever had any operations?		
Have you any minor recurring Problems e.g. hay fever		
Have you any allergies?		
Have you had a Tetanus in the last 10 years?		

FAMILY HISTORY

Have any members of your family (parents, grandparents, siblings) ever had any serious illness, e.g. heart disease, diabetes?

_____

_____

_____

Do you need/have anyone who looks after you or your daily needs as a career or are you a carer and do you help to look after someone who is elderly or unwell?

Please give details:

_____

_____

_____

_____

_____

PERSONAL INFORMATION

ALCOHOL CONSUMPTION – How many units per week do you consume?
E.g., Glass of wine = 2 units, Single shot of spirit = 1 unit, Pint of beer/larger/cider = 2 units

Beer (pints)	
Spirits (measures)	
Wine (glasses)	

SMOKING STATUS

	Please tick	**How many per day?**
Smoker		
Never smoked		
Ex-smoker		

If you are a current smoker, would you like us to make you a referral to the smoking cessation counsellor at Help Me Quit?

Yes □ No □

Height & Weight – Please tell us your most recent measurements for the following (if known)

Height: _____
Weight: _____

What is your ethnic origin:

Asian
Bangladeshi □
Indian □
Pakistani □
Other (specify below) □

Black or Black British
African □
Caribbean □
Other (specify below) □

White
British □
Irish □
Other (specify below) □

Mixed race
White and Asian □
White and Black African □
White and Black Caribbean □
Other (specify below) □

Other ethnic origin
Chinese □
Other (specify below) □

Please specify any other group

_____

What is your faith or religion, if any:

Islam □ Sikhism □ Judaism □ Hinduism □
Buddism □ Christianity (Anglican) □ Christianity (R.C.) □ Christianity (other) □
Jehovah's witness □ None □

Other please specify

_____

Are you Blind □ Partially sighted □ Deaf □ Hearing impaired □

Do you have any difficulties with reading or writing? If so, please state

_____

Do you suffer from a condition that may impair your communication? If so, please state

_____
_____

For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)

Have you had a flu vaccination? Yes □ No □

If yes, please give the date it was given: _____

Have you had a pneumococcal vaccination? Yes □ No □

If yes, please give the date it was given: _____

WOMEN ONLY

When did you have your last smear test? _____

Are you taking the contraceptive pill?
If yes, which one? _____

If no, are you using any other form of
contraception? _____

ANY OTHER INFORMATION YOU MAY THINK USEFUL:

Any special requirements on religious grounds.

_____

OFFICE USE ONLY

Proof of address type:

Staff name:

Date:

PONTPRENNAU MEDICAL CENTRE
ACCEPTABLE BEHAVIOUR CONTRACT

An Acceptable Behaviour Contract is a signed written agreement between an individual patient and a GP practice to make explicit that the patient will conduct themselves in an appropriate manner while on the premises and during consultations, and not carry out with certain identifiable behaviours, and that the practice will provide appropriate standards of care.

Patients Name: _____

Patients Address: _____

_____

The Conditions

I, (the Patient) agree the following in respect of my conduct whilst registered at Pontprennau Medical Centre:

1. I will not behave in any way which may be considered to be violent, threatening or abusive.

2. I will treat NHS staff, fellow patients, carers and visitors politely and with respect at all times.

3. I will not consume alcohol, smoke or take any form of non-prescribed medication or drugs whilst on the surgery premises.

4. I accept and understand that the practice is obliged to provide a safe and secure environment for its staff and to care for their health and safety.

5. I understand that if I display any aggressive, threatening or violent behaviour towards any member of staff employed at this surgery or put any of the staff or members of public in fear of their own safety, I will be removed from the practice list with the matter referred to the police.

We, Pontprennau Medical Centre, will:

1. Owe to you as a patient a duty of care and will aim at all times to provide services to meet your needs for primary healthcare and treatment.

2. Provide health services that are sympathetic and responsive to your individual needs within the resources that are available.

3. Deliver appropriate and effective health care and treatment to you.

4. Treat you with courtesy and respect.

Breach of this Contract:

If, (the Patient) breaches this following processes could be enforced:

- Removed from the practice list
- Reported to the police with view to charges being brought against them
- Considered by the Health Board for referral to the Alternative Treatment Scheme.

Declaration:

I confirm that I understand the meaning of this contract, and that the consequences of breaching the contract have been explained to me.

Signed (the Patient): _____ Date: _____

PONTPRENAU MEDICAL CENTRE

Eligibility Form

☐ I am a permanent resident in the UK (Wales).

☐ I am an ordinary resident in the UK (Wales) for a settled purpose (work, study) for at least six months.

☐ I have formally applied for asylum in the UK and my application is still under consideration by the Home Office.

☐ I am a refugee who has been given leave to retain in the UK.

☐ I have an emergency problem which requires necessary treatment immediately. This would *not* include having forgotten medication.

☐ I am not eligible for NHS treatment and need to be seen as a private patient*.

*Charge £100 for ten minute consultation.
Please be aware that there will be a charge payable to the pharmacy for a private prescription and the medication.

I am applying for registration as a patient at this practice and I declare my eligibility as identified above.

I understand that if my declaration is later found to be false, I may forfeit my right to treatment at this practice and may be liable for the cost of the treatment.

Signed: _____

Date: _____

(If child – signature of parent or guardian)