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| **DR ZARROUK (MALE DOCTOR)**  **THE SURGERY**  **65 BRADFORD STREET**  **BL2 1HT** | | | | | | | | | | | | | | | | | | | | | | |
| **Please ensure all questionnaire is fully completed as failure to do so will stop the registration process – all information will be stored in your medical records to help us provide your care** | | | | | | | | | | | | | | | | | | | | | | |
| **What title do you prefer to use? (Please circle)** | | | | | Mr | | | Mrs | | | | | Ms | | Miss | Master | | | None | | | Other – please state |
| **Full name:** | | | | | | | **Previous surname:** | | | | | | | | | | | **Date of Birth:** | | | | |
| **Full address:** | | | | | | | | | | | | **Contact details – please keep these updated**   * Home – * Mobile – * Work – * Emergency contact - * Email – * Consent to receiving text message reminders? YES/NO | | | | | | | | | | |
| **Sexual orientation: please circle**   * Homosexual * Heterosexual (straight) * Lesbian * Bisexual * In any other way – * Decline to answer | | | | | | | **Gender identity: please circle**   * Woman * Man * Non-binary * In any other way (please state) – * Is your gender identity the same as you were at birth? YES/NO | | | | | | | | | | | **Ethnicity:** | | | | |
| **Preferred language spoken:** | | | | |
| **Preferred method of communication:** | | | | |
| **Do you need an interpreter?**  YES/NO  **Please give details –** | | | | |
| **Residency status: Please circle**  Social migrant/asylum seeker/refugee/permanent resident/travel or student visa – **how long for?** | | | | | | | | | | | | | | | | | | | | | | |
| **Occupation:** | | | | | | | **Religion:** | | | | | | | | | | | **Marital status:** | | | | |
| **Next of kin (name):** | | | | | | | **Relationship to you:** | | | | | | | | | | | **Contact number:** | | | | |
| **If the answer is yes to any of the following medical questions below, please give details** | | | | | | | | | | | | | | | | | | | | | | |
| **Is there any history in your family of serious medical illnesses?** | | | | | | YES/NO – (example: heart disease, diabetes, high blood pressure, stroke, cancer) | | | | | | | | | | | | | | | | |
| **Do you suffer from ANY medical conditions?**  **It is important we are made aware of any health conditions which you may have.**  **If you are new into the country you will not have a medical record that will transfer over to us.** | | | | | | | | | | | | | | YES/NO – **if yes please state: (more space on next page if needed)** | | | | | | | | |
| **Do you have any allergies?** | | | | | | | | | | | | | | YES/NO – **If yes please state:** | | | | | | | | |
| **Are you a carer for someone?** | YES/NO  (Example – elderly relative, disabled person, paid carer for a child, **NOT** a carer by occupation | | | | If **YES**, who? | | | | | | | | | **Do you have a carer?** | | | YES/NO - In what way? | | | | | |
| **Are you a military service veteran:** | | | | | | | | | | | YES/NO | | | | | | | | | | | |
| **Weight (kg)** – | | | | | | | | | | | **Height (ft, in)** - | | | | | | | | | | | |
| **THE NEXT LOT OF QUESTIONS ARE FOR FEMALES ONLY** | | | | | | | | | | | | | | | | | | | | | | |
| **Are you pregnant?** | | YES/NO | | | | | | | **Any miscarriages/termination?** | | | | | | | | | | | YES/NO | | |
| **Names and dates of birth of children:** | | 1.  2.  3.  4. | | | | | | | | | | | | | | | | | | | | |
| **When was your last smear test:** | | | **Year:** | | | | | | | **Result:** | | | | | | | | | | | **Any treatments?** | |
| **Breast screening – if over 50** | | | | **YES/NO** | | | | | | **Outcome:** | | | | | | | | | | | | |

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| What is your smoking status? (please circle)   * Never smoked * Ex-smoker * Smoker – How many a day?   If you are a smoker you can receive help to stop smoking via the pharmacy.  Do you wish to have some help to stop smoking? YES/NO | | | | | Do you take any recreational drugs?  YES/NO/DECLINE  - **If yes, please state?** | | | | |
| **Please answer ALL 3 questions:** | | | | | | | | | |
| How often do you drink alcohol? | | | | | | | | | |
| N/A | | Once a month or less | | 2-4 times a month | | 2-3 times a week | | 4+ weekly | |
| How many units do you drink? | | | | | | | | | |
| N/A | 1-2 | | 3-4 | | 5-6 | | 7-9 | | 10+ |
| How often have you had 6 or more units if **FEMALE**, or 8 or more if **MALE**, on a single occasion in the last year? | | | | | | | | | |
| N/A | Never | | Less than monthly | | Monthly | | Weekly | | Daily or almost daily |

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| **Do you take any regular medications?**  If yes then please list all of the medications below and the dosages that you take **OR** (attach a copy of your repeat prescription) |
| Does your nominated chemist receive your prescriptions electronically? YES/NO  If **YES**, what chemist?  (If your current nominated chemist is too far away, don’t forget to let us know then we can nominate you to somewhere closer) |

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| Is there any additional information you would like to add? If yes please state below. |
| Please take your completed registration form to the reception in surgery. We will need some form of photo ID for example a passport, and some evidence to prove your address for example a utility bill or tenancy agreement.  If you are running out of your regular medications, we would advise you to get these from your present GP before moving as this will remove the risk of you running out before we obtain your medical records.  As part of our registration process you will be required to attend for a new patient registration health check with our nurse to assist us in your future care. |

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| Signature: | Date: |

**Dr. A. Zarrouk, MBB.Ch., MRCOG, MFFP.**

The Surgery

65 Bradford Street

Bolton

BL2 1HT

Telephone: 01204 521061

Fax: 01204 392009

Information for new patients

**Who is the doctor responsible for your care in this surgery?**

You may be aware that from April 2015 all practices are required to provide all their patients with a named GP who will have overall responsibility for the care and support that our surgery provides to them.

Even though our surgery is singlehanded which means that in this surgery there is only one doctor who is responsible for the care of ALL our patients. As a patient at this surgery, we have to inform you that your named GP is Dr Zarrouk.

Dr Zarrouk will have overall responsibility for the care and support that our surgery provides to you.

You do not need to take any further action, but if you have any questions, or wish to discuss this further with us, please contact us on 01204 521061.

Yours Sincerely

Dr A Zarrouk

**Patient Participation Group**

Are you interested in having a say or being consulted about issues in the surgery or the way we provide your care? We would like to know how we can improve our service to you.

To help us with this, we are setting up a patient participation group so that you can have your say. We will ask the members of this group some questions from time to time, such as what you think about our opening times or the quality of the care or service you received. We will contact you via email and keep our surveys short so as not to take up too much of your valuable time.

We aim to gather patients from as broad a spectrum to get as truly a representative sample as possible. We need young people, workers, retirees, people with long term conditions and people from non-British ethnic groups.

If you are happy for us to contact you occasionally by email or in person, please let us know by filling in the sign-up form and give it to reception staff. Thank you.