CHERITON BISHOP & TEIGN VALLEY
NEW PATIENT ASSESSMENT FORM

WELCOME TO CHERITON BISHOP & 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 telephone us on 01647 24272 and ask for a New Patient Assessment with the Practice Nurse and we will endeavour to find a convenient time for you to attend.

Please bring a specimen of your urine in a clear jar and any vaccination records you may have.

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

SURNAME …… FORENAMES ……..

DATE OF BIRTH …… TELEPHONE NO: ……..

MOBILE NO: …….. EMAIL ADDRESS: …….

MARRIED / SINGLE / DIVORCED / SEPARATED / WIDOWED …….. (Please delete as appropriate)

FULL NAME OF NEXT OF KIN …… RELATIONSHIP ……

CONTACT DETAILS: TELEPHONE: ……. MOBILE: ……

ADDRESS IF DIFFERENT FROM ABOVE ……

Can this person be used as your emergency contact …… Yes or No
Do you give your consent for this person to discuss your medical records …… Yes or No

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

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Are you a carer? If so, for whom ……
Do you or they receive help from Social Services ……Yes or No

Would you like us to send reminders about your appointment via Text messaging ……Yes or No

SIGNED …….. DATED ……

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ALLERGY INFORMATION:	
CURRENT MEDICAL PROBLEMS:	
CURRENT MEDICATION:	

Do you smoke ……Yes or No If so, How many a day…… If an ex-smoker please give date of stopping ……..	Alcohol: How many units per week…….	Height …… Weight …… Exercise: Regular …….. Yes or No Occasional …….. Yes or No Impossible …….. Yes or No

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

CONDITION	**RELATIVE (ie Father or Mother)**	**AGE OF ONSET**
HEART PROBLEMS		
HIGH CHOLESTEROL (OVER 7.5)		
RAISED BLOOD PRESSURE		
GLAUCOMA		
DIABETES		
ASTHMA		

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