**WALLASEY MEDICAL CENTRE**

**1 Wallasey Crescent, Ickenham, Middlesex UB10 8SA**

***Tel (surgery): 01895 674156 Fax: 01895 623334***

**www.wallaseymedicalcentre.co.uk**

**Dr Kitur P Patel**

**Registering with the practice (Please bring photocopies of documents only)**

Ickenham is our catchment area (UB10 8\*\*). See ‘registrations’ page on website for a map.

**New Patient Health Check**

As part of your registration, with this practice, you are required to have a Health Check with our Practice Nurse if you have any ongoing medical problems. If you are between 40 and 74 you may be invited for an NHS health check as part of the registration process even if you do not have a long term medical condition.

It is a 10 minute appointment and needs to be booked at the time of your registration, before an appointment can be booked with the GP.

Completing the questionnaire overleaf will also help the doctor, while waiting for your medical records to come through.

***Please note***

If you are on any medication, please arrange to collect a script from your previous GP, before you register with us. It takes approximately 6 weeks to receive your medical records from your old surgery. Thank you for your help.

Your named accountable GP is Dr Kitur Patel.

**Visit** [**www.wallaseymedicalcentre.co.uk**](http://www.wallaseymedicalcentre.co.uk) **for more information about the surgery.**

**Please make sure you familiarize yourself with our prescribing and other policies in the patient information section.**

**We advise all patients to seek advice for minor ailments via our website or from local pharmacies in the first instance. There is also a section on sicknotes for work and school which you may find useful.**

Please read and sign this page.

I have read the above information and completed the questionnaire.

Signed ……………………………..Dated ………………………..

**Patient Registration Details:**

Title: …… Forename: ……………………… Surname………………………… Date of Birth ………/………/………

Address………………………………................................................................................

Telephone No: ………………………………..………. Mobile Phone: ……………………………...............

Email address: …………………………………………. Occupation: ………………………………..................

Would you like **Patient Access**: YES/NO Access allows you to make appointments, request medication, view Blood Test results. If Yes please request a log in form one week from submitting registration forms.

Previous Address ……………………………………………………………………………………….………………………….

Previous GP name & Address……………………………………………………………………………………………..……

Town & Country of birth ………………………………..........................................................................

Main Spoken Language: ……………………………. Ethnicity……………………………………

**FAMILY HISTORY**

Age: State of health: Or Cause of Death:

Father ……………….. ………………….. …….…….………….

Mother ……………….. ………………….. …….…….………….

Is there any significant family history of illness? (e.g. Heart disease, Strokes, Asthma, Diabetes.)

………………………………...............................................................................................

………………………………...............................................................................................

PLEASE RECORD BELOW ANY PAST OR PRESENT ILLNESS OR OPERATIONS.

E.g. Heart or Lung problems, Diabetes, Epilepsy, High Blood Pressure or Nervous Problems

A………………………………..........................................................................................

B………………………………..........................................................................................

C………………………………..........................................................................................

Height ……………….Weight……………………………Blood Pressure………………….

Allergies:……………………………...........................................................................

Cigarettes/day: ………… Alcohol / Week: ……… Latest Tetanus Injection: ……/……/…....

Current Medication: ………………………………...................................................................................

**Women**

Date of Last Cervical Smear …..…/………/........ Result: Normal / required treatment

**Children**

Have all immunisation courses been completed? YES / NO (please complete the additional form)

**Thank you for filling in the questionnaire and welcome to the surgery.**

**OFFICE USE ONLY: Identity checks**

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| **PHOTO** CHECKED (STAFF): TYPE OF ID: DATE: / / |
| **ADDRESS** CHECKED (STAFF): TYPE OF ID: DATE: / / |