Park Road Practice
Health Centre, Rosyth, Fife, KY11 2SE
Tel: 01383-418931

Welcome to Park Road Practice.

Today you have indicated your wish to register with the Practice to obtain General Medical Services. To assist us we will provide you with some information about the Practice and how we operate and we will also require from you some personal information regarding your current health status.

We are providing you with the following documentation:

- **NHS SCOTLAND GPR REGISTRATION FORM.** Please complete this form as fully as possible before returning to Reception. Please ensure the form is signed and dated. For all new registrations we require proof of ID. Where possible this should be with photographic ID eg passport, driver's licence. Where no such ID exists then a birth certificate or NHS card will be accepted. – **Please note that the person who is on the photographic ID is the person who is required to register *(you cannot register on behalf any anyone else)***

- **NEW PATIENT QUESTIONNAIRE.** Please complete this form as fully as possible and note the following: **Where a Patient has previously received medication on a repeat prescription no medication will be issued from this Practice on a repeat basis until an appointment has been made for a medication review with a GP Partner. Please also note that in prescribing medicines you may need to attend for periodic checking/ testing. Failure to comply with this monitoring will mean we will no longer be able to issue these medicines.**

- **ETHNICITY MONITORING FORM.** Please complete this form by ticking the boxes which best apply to you.

- **TEXT CONSENT FORM.** This Practice is actively encouraging patients over the age of 13 with a mobile phone to sign up to our text messaging service which will send text reminders for certain clinic appointments. ***We can only register one number per patient*.** If you would like to sign up to this process please complete the form and return to Reception with your new registration documents.

- **Consent Forms:** Please note that all children over the age of 12 and under 16 will be required to give an adult over the age 16 consent to discuss matter on their behalf (please complete the attached consent form)

- **PRACTICE LEAFLET.** This leaflet details more about our team and the services we provide to our Patients. This leaflet is also available by visiting our Practice website which is available at www.parkroad.gpsurgery.net **– You can also register on the website for vision on line where you can request prescriptions.**

Park Road Practice – Patient Questionnaire

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care.

If you have a letter from the Home Office granting you Limited Leave in the UK/pre-settled status, could you please bring this with you so that we can take copies for your records. This may assist in any delays with referrals to other agencies.

We should be grateful if you can complete one for each family member joining the practice.

Name:.....DOB:.....

Do you need an interpreter of sign language support [ ] YES [ ] NO

If you do need an interpreter, what language do you speak?.....

What is you ethnic group? Chose **ONE** which best describes your ethnic group or background.

WHITE

[ ] Scottish

[ ] English

[ ] Welsh

[ ] Northern Irish

[ ] British

[ ] Irish

[ ] Gypsy/Traveller

[ ] Polish

[ ] Any other group.....

Mixed or multiple ethnic groups

[ ] Any mixed or multiple ethnic group

Asian, Asian Scottish or Asian British

[ ] Pakistani, Pakistani Scottish or Pakistani British

[ ] Indian, Indian Scottish, Indian British

[ ] Bangladeshi, Bangladeshi Scottish or Bangladeshi British

[ ] Chinese, Chinese Scottish or Chinese British

[ ] Other Please write.....

African, Caribbean or Black

[ ] African, African Scottish, African British

[ ] Caribbean, Caribbean Scottish, Caribbean British

[ ] Black, Black Scottish, Black British

Other Ethnic Group

[ ] Arab

[ ] Other Please write.....

If you DO NOT wish to provide any information above please tick here [ ]

Park Road Practice

New Patient Questionnaire to be completed for all patients this form is for all adults over the age if 16 please hand back with your GP registration form.

Full Name:	Date of Birth
Address:	Marital Status
	Next of Kin: Name: Address: Contact Number
Contact information: Home: Mobile: Email:	

Height: Weight:

Are you the parent/carer of anyone under the age of 16? YES/NO If so please provide the names and DOB: Does anyone else live in your household. YES / NO If so please provide their names:

Are you taking any Medication? If yes please list below:

If you have a repeat prescription from your previous practice please attach

Please note that if you are on 5 or less medications you will need a 10 minute telephone consultation with the Dr before we can prescribe any medication, this will be made when you hand in the registration forms, and if you are more than 5 we will make you a double appointment. Please note the appointment is to discuss your medication ***ONLY.***

Name of Medication	Dosage and Frequency

Name of Medication	Dosage and Frequency

Do you have any allergies – if so please list below

Drug Related Allergies	
Non Drug Related	

Personal & Family History

Have **YOU** or anyone in your family ever suffered or have a history of any of the following medical conditions?	Tick if YES	Approx date of diagnosis	Please say who in the family be it yourself – parents- grandparents – and age when diagnosed.
Heart Disease			
Stroke			
Heart Problems			
High Blood Pressure			
Asthma			
Chronic Obstructive Pulmonary Disease			
Other Chest Problems			
Diabetes			
Epilepsy			
Hypothyroidism (Thyroid Deficiency)			
Cancer			
Mental Health Problems			
Learning Difficulties			
Had an operation			
Depression/Anxiety			
Other Mental Health			
Other/More details			

Smoking

Do you currently smoke	YES NO
If **NO** have you ever smoked	YES NO
Have you ever used an e-cigarette or vaporiser	YES NO
If you smoke how much tobacco do you consume daily	
Do you have any concerns about any other addictions	

Alcohol

Please circle the amount of units that closely describe your usual average alcohol intake (1 unit = 1 glass of wine, ½ pint of beer or a single measure of spirit)

I never drink alcohol Less than one unit per day 1- 2 units per day	3-6 units per day 7-9 units per day More than 9 units per day
Have you ever felt you need to cut down on your drinking	YES NO
Have people annoyed you by criticising your drinking	YES NO
Have you ever felt guilty about drinking	YES NO
Have you ever felt like you needed a drink first thing in the morning to steady your nerves or to get rid of a hangover	YES NO

Relationships

Are you in a relationship	YES NO
Would you like help with contraception?	YES NO
Do you currently use any contraception	YES NO
If yes what do you use as a form of contraception	

Exercise

Health exercise involves activity that usually last for at least 20 minutes, raises your pulse and produces hard breathing. In younger people this might be running, cycling, aerobics or swimming. For older people this may be a brisk walk.

Please complete the box below

Daily	
4 times a week	
Once a week	
Seldom	
I cannot take exercise because of disability	

Is there anything that worries you about your health?
Is there anything about your health you would like to make better

Immunisations

1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib & Hep B	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib & Hep B	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib & Hep B	
1st Rotavirus	
2nd Rotavirus	
1st Meningitis B (8 weeks)	
2nd Meningitis B (16 weeks)	
3rd Meningitis B (12/13 months)	
1st Prevenar (8 weeks)	
2nd Prevenar (16 weeks)	
3rd Prevenar (12/13 months)	
Hib/Men C (12/13 months)	
MenCAWY (14 years)	
HPV (11/13 years)	
1st MMR (13 months)	
2nd MMR (3 years 4 months)	
Booster MMR	
BCG/TB	
Tetanus/IPV – Revaxis (14 years)	
Any other immunisations	

Female applicants only
CERVICAL CYTOLOGY CONFIRMATION

Please fill in one section below:

I herby confirm that I had a cervical smear performed:
Country:
When:
The result was reported to me as : Normal/Abnormal
I was advised to next have my smear done on (approx date)

I have never had a cervical smear but wish to be invited:

Thank you for your assistance in completing this questionnaire

Please hand back with your GP registration form.

Park Road Practice

Consent to Access Medical Information

All patients over the age of 14 must sign if they wish their parents/guardians to discuss with the Dr on their behalf.

Patient Name:	
Date of Birth:	
Home Telephone Number:	
Mobile Telephone Number:	

I.....The above patient hereby give my consent for my representative.....Relationship to the patient.....Contact telephone number for the representative.....to speak to the surgery on my behalf.

Signed.....Date.....

Patient

Signed.....Date.....

Representative

Park Road Practice

EKIS (electronic key information summary)

Patient Name:	
Date of Birth:	
Home Telephone Number:	
Mobile Telephone Number:	
Email Address:	

Would you be willing to have your name added to this service this will enable hospitals and ambulance medics to be able to view your relevant medical history.

Yes or No (please circle)

For further information please see
https://www.snughealth.org.uk/gp-software/ecs-and-kis/key-information-summary/

Park Road Practice

Text Message / Email Consent Form Age 16 and over

Patient Name:	
Date of Birth:	
Home Telephone Number:	
Mobile Telephone Number:	
Email Address:	

Declaration

I consent to the practice contacting me by text message or email for the purposes of health promotion and or appointment reminders.

I acknowledge that appointment reminders are an additional service and that they may not be sent on all occasions but that the responsibility for attending appointments or cancelling them still rests with me.

I can cancel text message facility at any time.

Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure however the practice will not transmit any information which would enable an individual patient to be identified.

ONLY ONE NUMBER PER PATIENT WILL BE ACCECPTED

You can also register for Vision Online Services, which allows you to book appointments and request prescriptions.

Please see our website : www.parkroad.gpsurgery.net