The Apples Medical Centre

**East Mill Lane**

# Sherborne

## Dorset DT9 3DG

[**www.sherborneapples.co.uk**](http://www.sherborneapples.co.uk)

Tel: 01935 812633

### Dr. Rob Lewis Fax: 01935 817484

**Dr. Angela Tweedie**

**Dr. Chris Minton**

**Dr. Dom Parsons applesmedcentre@nhs.net**

Dear Patient

**Welcome to the Apples Medical Centre**

Please fill out the **New Patient Health Questionnaire** overleaf.

If you are on repeat medication, we advise that you have at least 2-4wks supply before registering. Once we have your registration form, we will offer you a telephone appointment with one of our Pharmacists who will go through your medication with you and update our records.

You can also arrange to **Book On-Line** to issue your repeat prescriptions. To obtain your password from reception requires the presentation of one form of photo identification and one proof of address document.

We have a**Patient Participation Group** at the surgery. If you would like to join this group, then please ask for details at reception.

If you have downloaded the questionnaire from our website, please feel free to complete it on a computer or by hand. We require that the form be signed and dated, which ever method you have chosen. Once you have completed the questionnaire please bring it to reception along with your completed GMS registration form and proof of identity and address.

Yours faithfully,

Philippa Cannings

Practice Manager

**PTO to complete the Patient Health Questionnaire**

THE APPLES MEDICAL CENTRE – NEW PATIENT HEALTH QUESTIONNAIRE

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename |  |
| Previous name |  | Title |  | D.O.B |  |
| Tel No. |  | Mobile No. |  |
| Email |  |
| Occupation/Previous occupation |  |
| Next of Kin |  |
| Relationship to you |  | N.O.K. Contact no. |  |
| Your Ethnic Origin |  | 1st Language |  |
| Communication preferences(Sign language, large print, braille, easy read etc.) |  |
| Are you a Carer? | Yes [ ]  No [ ]  | Are you cared for? | Yes [ ]  No [ ]  |
| Name, address and telephone number of carer or person you care for |  |
| Name & address of previous doctor |  |

# YOUR MEDICAL HISTORY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Asthma** | Yes [ ]  No [ ]  |  **High BP** | Yes [ ]  No [ ]  | **Cancer** | Yes [ ]  No [ ]  |
| **Diabetes** | Yes [ ]  No [ ]  | **Epilepsy** | Yes [ ]  No [ ]  | **Glaucoma** | Yes [ ]  No [ ]  |
| **Heart Problems** | Yes [ ]  No [ ]  |  **Stroke** | Yes [ ]  No [ ]  | Other |  |
| **Operations and Dates** |  |
| Do you have any disabilities? |  | Do you wear a hearing aid? | Yes [ ]  No [ ]  |

**DRUGS AND MEDICINE**

If you are taking regular medication, please bring the **repeat** **prescription slip to your new patient check.**

|  |  |
| --- | --- |
| Do you have **any allergies** or drug sensitivities? |  |

PERSONAL HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| Do you drink alcohol? | No [ ]  Yes [ ]   | How units consumed per week? | u/wk. |
| Never smoked   | [ ]  | Ex-smoker  | [ ]  | When did you quit? |  |
| If a current smoker, how many cigarettes/cigars/ounces smoked per day? | /day |
| Weight |  | Height |  |
| - if you would like to opt out of the surgery contacting you via email/SMS please tick this boxIf you supply us with an e-mail address consent is implied for contact by this method. |  [ ]  |
| Veterans: Priority NHS treatment-Please tick if you are a military veteran |  [ ]  |