



CHERRY VALLEY  
GROUP PRACTICE

**New Patient Medical**

<b>Surname:</b> _____	<b>Forenames:</b> _____
<b>DOB:</b> _____	<b>Language Spoken:</b> _____ <b>Interpreter Needed:</b> YES NO
<b>Address:</b> _____ _____ _____ <b>Postcode:</b> _____	<b>Phone:</b> _____ <b>Mobile:</b> _____ <b>Email:</b> _____

**Any family members registered at the Practice (please state who and your relationship to them) :**

\_\_\_\_\_

**Repeat Medication:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you have any allergies?** \_\_\_\_\_

**If yes, please state reaction:** \_\_\_\_\_

**Please list any illnesses, operations etc including dates (continue on separate page if necessary):**

\_\_\_\_\_

\_\_\_\_\_

**Height** \_\_\_\_\_

**Weight** \_\_\_\_\_

**Please indicate smoking status: Current Smoker / Ex-Smoker / Never Smoked**

**If current or ex-smoker:**

**Number of years smoked?** \_\_\_\_\_ **How many per day?** \_\_\_\_\_

**Do you drink alcohol (units per week)?** YES/NO \_\_\_\_\_ (units)

### **Practice Medication Policy**

**The drugs listed below can be dangerous long-term. Practice Policy is to work with our patients to reduce the use of these drugs.**

**Diazepam, Temazepam, Nitrazepam, Lorazepam, Tramadol, Zopiclone, Zolpidem, Dihydrocodeine and Codeine**

**If you are currently being prescribed any of these medications , please note that as a New Patient in our Practice it is our policy to review the reason you are on them and seek safer alternatives.**

**I have read and understood the Practice Policy on these drugs.**

**I do not take any of the above medication.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### **Ethnicity**

**We are required to ask all our newly registered patients what they consider their Ethnic Group to be. Your treatment will not be affected in any way by the data.**

**White** \_\_\_\_\_

**Other White** \_\_\_\_\_

**African** \_\_\_\_\_

**Mixed White & Black African** \_\_\_\_\_

**Caribbean** \_\_\_\_\_

**Mixed White & Black Caribbean** \_\_\_\_\_

**Chinese** \_\_\_\_\_

**Other Ethnic Group** \_\_\_\_\_

**YOU WILL NOT BE REGISTERED WITH THE PRACTICE UNTIL YOUR APPLICATION HAS BEEN APPROVED**

**A MEMBER OF STAFF WILL CONTACT YOU WHEN YOUR APPLICATION HAS BEEN APPROVED**