

**Torcross Medical Centre**

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Application Form

At present the Torcross Medical Practice has a much higher than average number of patients per doctor, and therefore we are unable to offer a completely open list.

 If you wish to apply to join our medical list, please complete all of this form. Please try to include as much information as possible, this will assist us in assessing your health needs and will act as our only record of your medical history until your medical notes have been received. Please inform reception if you have any difficulty completing this form due to any disability, sensory impairment or language barriers. Once you have completed the form, hand it in at reception or post it to us. You will need to produce proof of ID (passport, driving licence etc.) and proof of address (utility bill etc.)

We will usually be able to advise whether you will be able to join our list after two working days. You may ask at reception or telephone during our usual working hours.

We are presently only able to take patients who are within our practice area. Our practice area is limited by the boundaries of Binley Road, Swan Lane, Red Lane, St Paul’s Road, Foleshill Road and the city boundaries to the north and east. In addition we also cover the Warwickshire villages of Barnacle, Shilton and Ansty.

Once you have been accepted to join the list you will need to have a new patient medical with the practice nurse.

When attending your new patient medical please bring a sample of urine, (a specimen pot will be provided) and all tablets, creams, inhalers etc that you use.

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| PLEASE NOTE:UNTIL YOU HAVE HAD A NEW PATIENT MEDICAL YOU WILL **NOT** BE REGISTERED WITH TORCROSS MEDICAL CENTRE. |

Date of application: \_\_/ \_\_/ \_\_

Title: □Mr. □Mrs. □Miss. □Ms. □Dr. □Other

Marital Status: □Married □Single □Other

|  |  |  |  |
| --- | --- | --- | --- |
| Surname |  | Forename |  |
| Address |  |  |  |
| Postcode |  | Telephone number |  |
| Mobile number |  | Date of Birth |  |
| Previous Address |  |  |  |
| Occupation |  |  |  |
| Previous GP (name |  | Previous GP address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Height |  | Weight (kg/stones) |  |

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| **Brief medical history (include all operations and significant illnesses)** |
| **Approximate date** | **Details of illness.** |
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| **Current Medication (include all tablets, mixtures, creams, inhalers, sprays etc.)** |
| Name of Drug(Eg. Paracetamol) | Size of dose (eg. 500mg) | Frequency of Dose(Eg. Twice daily) |
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 Continue on a separate sheet if needed.

**Dates of last immunisations**

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| --- | --- | --- | --- | --- | --- |
| **DPT/Polio** |  | **Measles/MMR** |  | **BCG** |  |
| **Rubella** |  | **Tetanus** |  |  |  |

**Are you allergic to any medicine/food**? □No □Yes (details)

**How much do you smoke?** □Never smoked □Ex smoker for \_\_\_ years,

□Cigarettes \_\_ per day, □Cigars \_\_ per day

**How many units of alcohol do you drink per week?**

*(One unit = glass of wine, half pint of beer or a single of spirits)*

□None □Less than 1 □Less than 14 □14 to 21 □More than 21 \_\_\_

**How often do you have 8 or more drinks on one occasion?**

□Never □Less than monthly □Monthly □Weekly □Daily or almost daily

**How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

□Never □Less than monthly □Monthly □Weekly □Daily or almost daily

**How often during the last year have you failed to do what was normally expected of you because of your drinking?**

□Never □Less than monthly □Monthly □Weekly □Daily or almost daily

**Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?**

□No □Yes, but not in the last year □Yes, in the last year.

**How many times do you exercise each week?**

□None □Less than once □Once or twice □More than twice

**Are you on a special diet?**

□No □Diabetic □Low fat □Gluten free

□Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a family history of any of the following diseases?**

□Heart disease before age of 65? □Cancer □Diabetes □High blood pressure, □Asthma

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| **Females only:**Cervical smear □Never had, □Date of last smear \_\_/ \_\_/ \_\_Breast screening □Never had, □Date of last test \_\_/ \_\_/ \_\_ |

Language if other than English \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Ethnic Category (please tick)** |
| White | **British** |  |
|  | **Irish** |  |
|  | **Other White** |  |
|  |  |  |
| Mixed | **White & Black** **Caribbean** |  |
|  | **White & Black** **African** |  |
|  | **White & Asian** |  |
|  | **Other Mixed** |  |
|  |  |  |
| Asian or Asian British | **Indian** |  |
| **Pakistani** |  |
|  | **Bangladeshi** |  |
|  | **Other Asian** |  |
|  |  |  |
| Black or Black British | **Black** **Caribbean** |  |
| **Black African** |  |
|  | **Other Black** |  |
|  |  |  |
| Other Ethnic | **Chinese** |  |
|  | **Other Ethnic Group** |  |
|  |  |  |
| Not Stated | **Not Stated** |  |

**Torcross Medical Centre is supporting Summary Care Records and as a patient you have a choice:**

□ Yes, I would like a Summary Care Record. If you want a record please tick the box and one will be created for you when you register with this practice.

□No, I do not want a Summary Care Record. If you do not want a record, you will need to fill in the Summary Care Record opt out form and hand it in to reception. You should do this even if you have already completed a form at your previous practice. Opt out forms are available from reception.

You are free to change your decision at any time by informing the practice

Proof of ID seen □Yes □No

Photo ID.

Passport □

Driving licence □

Other □ (please state) ……………………………………………..

Proof of address seen □Yes □No.

*Office use: …………………………………………………………………………………………….□Yes □No*

*Date of NPM \_\_/ \_\_/ \_\_*