Taunton Road Medical Centre

12-16 Taunton Road, Bridgwater, Somerset. TA6 3LS

Telephone: 01278 720000 **Prescriptions: 01278 720005**
Fax: 01278 423691 **Website:** www.trmc.co.uk

STRICTLY CONFIDENTIAL

Registration Form – Over 16 Years Old

Welcome to Taunton Road Medical Centre. Before we accept you onto our list we ask all potential new patients to complete this important questionnaire, along with the purple GMS1 form attached, and return them to the practice as soon as possible.

The information that you provide on this form, along with that contained within your medical records from your previous Practice (which can take up to several months to arrive), is very helpful for us to have prior to registering you as a patient, so please answer the below questions in as much detail as possible.

YOUR PERSONAL DETAILS

Title: …… First Name: ……..

Surname: …… DOB: ……

Current Address:

……

……

……

Postcode: …… Mobile Telephone: ……

Home Telephone: …… Email: ……

Ethnic Group: ……

Your main spoken language(s): ……..

Do you require a translator for your appointments? Yes ☐ No ☐

Have you previously been registered at this practice? Yes ☐ No ☐

Please provide in full your reason for applying to join our Medical List (e.g. you have recently moved to Bridgwater)

……

Have you recently been in hospital?

If yes: Which Hospital: …… Date of Discharge: ……

Have you served in the Armed Forces?

If yes: Which Service: …… Enlistment Date: …… Discharge Date: ……

CARING

Are you a carer? Yes ☐ No ☐

If **yes**, who do you care for:

Name: ……

Relationship: ……

Contact tel: ……

Do you have a carer? Yes ☐ No ☐

If **yes**, who is your carer:

Name: ……

Relationship: ……

Contact tel: ……

EMERGENCY CONTACT

We would like to record the details of the person that you would like us to contact in the event of a medical emergency; these details will be held on your medical record.

In case of an emergency, please contact:

Gender: Male/Female Title: ……

First Name: …… Surname: ……

Date of Birth: …… Relationship e.g. Mother, Father etc: ……

Contact Number: ……

Are they registered here at TRMC: Yes/No

Please note that emergency contact details will remain on your record unless you contact us to request that they are updated or removed.

ACCESSIBLE INFORMATION STANDARD

Do you have difficulty hearing, or need hearing aids or need to lip-read what people say?
Yes ☐ No ☐

Do you have difficulty with memory or ability to concentrate, learn or understand?
Yes ☐ No ☐

Do you have difficulty speaking or using language to communicate or make your needs known?
Yes ☐ No ☐

Do you have any special communication requirements/require specific communication support?

	Sign language
	British Sign Language
	Tadoma sign language
	Lip reading
	Manual or electronic note taker
	Speech to text reporter
	Deafblind intervener
	Loop system
	Other:

What is the best way to send you information?

	Telephone
	Letter
	Email
	Other:

Do you need a format other than standard print?

	Braille
	Easy Read
	Large print e.g. at least 20 point font
	Other:

Do you need an assistance of Communication Professional?

	Interpreter for Deafblind People
	BSL Interpreter
	Lip speaker
	Note taker
	Sign Language Translator
	Other:

Do you need an advocate? (Someone who will support you to communicate or to express your point of view) ` Yes ☐ No ☐

PERSONAL INFORMATION

Height:	cm/ft. in	Weight:	st/kg
Blood Pressure Reading (if you have a home monitor)		_____/_____ mmHg	

Smoking Status:

☐ Never Smoked

☐ Current Smoker No of cigarettes per day: ……..

Amount of tobacco per week: ……..

☐ Ex-Smoker Date given up: ……..

Would you like information on how to stop smoking? Yes ☐ No ☐

Occupation: ……

Exercise:

☐ I avoid exercise ☐ Exercise is physically impossible for me

☐ I enjoy light exercise ☐ I enjoy moderate exercise ☐ I enjoy heavy exercise

MEDICAL INFORMATION

Allergies:

Do you have an allergy? Yes ☐ No ☐

If yes, what are you allergic to? ……..

Please describe the allergic reaction you have to this substance:

……..

Medical History:

Do you suffer from any of the following conditions? (Please tick)

☐ Coronary Heart Disease
☐ Heart Failure
☐ Atrial Fibrillation
☐ Diabetes
☐ COPD or Chronic Chest Problems
☐ Asthma
☐ Chronic Kidney Disease
☐ Thyroid Problems
☐ Epilepsy
☐ Cancer
☐ On-going Mental Health Problems
☐ Depression
☐ Dementia
☐ Have you ever had a stroke?
☐ Hypertension (High Blood Pressure)
☐ High Cholesterol
☐ Obesity
☐ Are you terminally ill?

Please list any other conditions you have:

……..

FAMILY MEDICAL HISTORY (i.e. parents, siblings, grandparents, uncles & aunts)

Has a family member had a heart attack or heart problems BELOW age 60? Yes ☐ No ☐

If **yes**, which member? ……

Has a family member had a stroke BELOW age 60? Yes ☐ No ☐

If **yes**, which member? ……

Has a family member had the following?

- o High Cholesterol If so, which family member? ……
- o Glaucoma If so, which family member? ……
- o Bowel Cancer If so, which family member? ……
- o Breast Cancer If so, which family member? ……
- o Diabetes If so, which family member? ……

SEXUAL HEALTH

If you are aged 16-24 and have ever had sexual intercourse, you should be screened for the infection Chlamydia. Many people have the infection but have no symptoms but as it can cause infertility it is important to get screened and then treated if you have the infection. Self-test packs are available from reception and in the patient toilets.

Local Sexual Health Services:

Somerset-Wide Integrated Sexual Health Service (SWISH):

Telephone: 0300 124 5010

Website: www.swishservices.co.uk

Women Only:

Date of last cervical smear: ……

Result of last cervical smear:

☐ Negative ☐ Abnormal

☐ Inadequate ☐ Other

Do you currently use contraception? Yes ☐ No ☐ Type ……

MEDICATION

Current Medication:

Do you take any over the counter medicine – like aspirin – regularly? Yes ☐ No ☐

If so, what do you take? ……

If you are on medications please attach your prescription counterfoil to this form or list your medication below:

Drug Name	Dose	Number per day

If you are on repeat prescription and would like these to be sent directly to a pharmacy please select your pharmacy below:

I HEREBY AUTHORISE THE FOLLOWING PHARMACY TO COLLECT MY PRESCRIPTIONS FROM TAUNTON ROAD MEDICAL CENTRE

Please tick **ONLY ONE BOX**, as appropriate:

ASDA BRIDGWATER	☐	LLOYDS REDGATE	☐
BOOTS	☐	LLOYDS SAINSBURYS	☐
CRANLEIGH GARDENS	☐	LLOYDS TAUNTON ROAD	☐
JHOOTS SOMERSET BRIDGE	☐	ROWLANDS, QUAYSIDE	☐
JHOOTS VICTORIA PARK	☐	SUPERDRUG	☐
LLOYDS NORTH PETHERTON	☐	STOCKMOOR PHARMACY	☐

Upon completion and processing of this form, all of your prescriptions will be automatically sent to the pharmacy as indicated above, unless you are informed otherwise. If you would like to change your pharmacy preference at any time you will need to complete another form.

ONLINE SERVICES

We offer some online services. You can now order any repeat medication online 24 hours a day and 7 days a week. This reduces errors and also avoids calling the busy prescription line. You can also view parts of your medical record (currently medications and allergies), as well as book and cancel appointments. If you would like these services once registered, please complete the next page and provide photographic ID when returning this registration form. This service is only available for patients over the age of 16.

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PATIENT ACCESS REQUEST FORM

Patient Access is an easy way of requesting repeat prescriptions, booking appointments, checking to see when your next appointment is, accessing self-referrals and much more. You can request a prescription via eConsult or the NHS App, but Patient Access does not require you to complete a form every time you request a repeat prescription.

If you would like us to issue your login details, please complete the form below and email it to supervisor.trmc@nhs.net. You will then be contacted by a member of the Reception Team when you patient access information is ready for collection from the surgery. For security reasons you will need to collect your login details with photographic identification.

Please print clearly:

First Name _____ Surname _____

Date of Birth _____

Address _____

Postcode _____

Mobile Number _____ Email address: _____

I confirm that I am consenting for Taunton Road Medical Centre to issue me my login details for Patient Access. I am fully aware that it is my responsibility to ensure that I keep this information secure and I understand that failing to do so may result in others being able to access my details online.

Signature _____ Date_____

_____

For office use:

- ☐ Online access set up and details printed
- ☐ Online access pack issued
- ☐ Patient is aware their information is ready to collect

Date: _____ Initials: _____

TEXT MESSAGING

If you would like to sign up to receive text messages from the practice, please complete the section below.

I confirm that I am consenting for Taunton Road Medical Centre to send me text messages. I am fully aware that it is my responsibility to ensure that if I change my mobile number I inform the practice straight away.

I understand that failing to do so may result in a breach of patient confidentiality. I understand that this consent will be added to my medical records.

Signature _____ Date_____

ALCOHOL (PLEASE TURN OVER TO ANSWER)

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Signature: ..... Date: .....

Please return completed questionnaire to TRMC

Updated 24.11.2020