



Vine
Medical Group



Register as a patient

You need to **register with us** to receive your medical care.

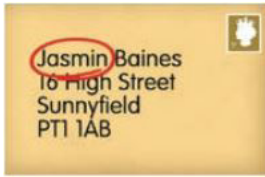
Please complete this form and then hand in to reception at Vine Medical Group.

V2.0

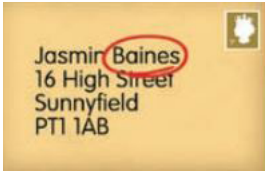
Vine Medical Group, Forest End Site, Forest End, Waterlooville, Hampshire, PO7 7AH
Email: hiowicb-hsi.vinemedicalgroup@nhs.net • Website: www.vinemedicalgroup.co.uk

Your name and address

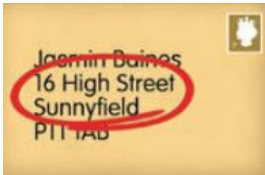
Your first names



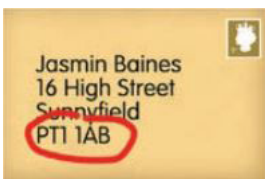
Your surname



Your address



Your postcode



Your home telephone number



Your mobile telephone number





Married or single?

I am married

I have a partner (not married)

I am single



Your sexuality

Straight / Heterosexual

Gay / Lesbian

Bisexual

Other

I would rather not say

I am not sure



What is your date of birth?



Were you born in the UK?

Yes

No



If you were not born in the UK, what country were you born?

What is your main spoken language?



Other languages you speak, if any?



Do you need an interpreter to help you with your first language?

Yes

No



Your ethnicity (where your family is from)

White or White British

Asian or Asian British

Black, Black British, Caribbean or African

Mixed or multiple ethnic groups

Other

If other, please write it here

Name and address of your last GP





Do you have a disability?

I have a learning disability

I have a physical disability

Other

I do not have a disability

I would rather not say



Do you need reasonable adjustments?

Longer appointment

Easy Read

Support from my parents / carers

Other



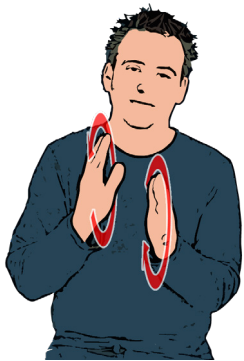
If other, please write it here



Do you have communication needs?

Yes

No



If yes, how do you communicate?

I lip read

British Sign Language (BSL)

Makaton

Other

If other, please write it here



Do you attend the following?

School

College

University

What is the name of your school, college or university?



Do you have a job or volunteer?

I work

I volunteer

No

If yes, where do you work or volunteer?

Do you require support? If so, please complete the below:



Name of your parent(s)



Contact details of your parent(s)



Your parent(s) telephone number

For your parent(s) to sign

I give consent for my details to be held, as a parent, by Vine Medical Group.

Yes

No

Date

Signed

Do you have a carer?

If so, please complete the below:



Name of your carer(s)



Your carer(s) telephone number



Would you like your carer(s) to deal with health matters at Vine Medical Group?

Yes

No

For your carer(s) to sign

I give consent for my details to be held, as a carer, by Vine Medical Group.

Yes

No

Date

Signed



Are you a carer for anyone else?



Yes

No

If yes, someone from the surgery will talk to you about this.

Your Next of Kin

Your next of kin is usually your closest family member or someone you trust.



Name of your next of kin



Contact details of your next of kin



Their relationship to you

Your diet and lifestyle



Do you smoke?

Yes

No

Sometimes

I used to smoke but stopped



Do people ever smoke around you?

Yes

No



Do you drink alcohol?

Yes

No



How much do you weigh?

kg

Stone

Pounds



How tall are you?

cm

Feet

Inches

Please continue on the next page.

Your medical history

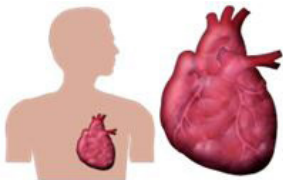


Are you allergic to anything?

Yes

No

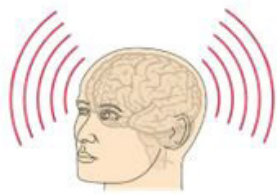
If yes, please give details here:



Do you have or have you had heart disease (heart attacks, angina)?

Yes

No



Do you have or have you had a stroke?

Yes

No



Do you have asthma?

Yes

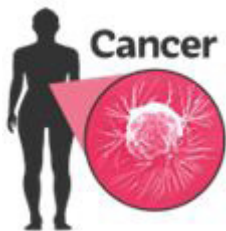
No



Do you have diabetes?

Yes

No



Do you have cancer?

Yes

No



Please tell us about any other health issues you may have.



Where would you like to collect your prescriptions from?

Please continue on the next page.

Please sign and date this form

Signed by patient



Signed by carer (if applicable)

Date



**Thank you for completing
this form.**

We will read this and contact you to
arrange a health check.

If you have any questions about this
form or a health check, please contact us
on:

023 9226 3089