Western Vale
Family Practice

The Broad Shoard, Cowbridge, CF71 7DA
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www.cowbridgedoctors.com

REGISTRATION FORM

Large print questionnaire for visually impaired available upon request

Personal Details

Surname:	
First Names:	
Date of Birth:	
Sex:	Male ☐ Female ☐
Address:	
Postcode:	
Military Veteran:	No ☐ Yes ☐
Email Address:	
Home Telephone Number:	
Mobile Telephone Number:	

Medical History

Diabetes: ☐
Heart Disease: ☐
High Blood Pressure: ☐
Epilepsy: ☐
Asthma: ☐

Medication and Pharmacy

Allergic to Medication: No ☐ Yes ☐ Which medication: ____________________

If you would like your prescriptions to be sent directly to a pharmacy:

Sylvia Williams (Cowbridge) ☐
Lloyds (Cowbridge) ☐
Wells (Llantwit Major) ☐
Boots (Llantwit Major) ☐
St Athan ☐
Tesco (Talbot Green) ☐
Ann Williams (Pontyclun) ☐
Pontyclun Pharmacy ☐
Other ____________________

Disability

If you are disabled or have a specific learning difficulty please let us know:

Registered blind: ☐
Sight impaired: ☐
Deaf: ☐
Hearing impaired: ☐
Wheelchair user: ☐
Mobility difficulties: ☐
Disability not listed: ☐
Autistic Spectrum Disorder: ☐
Asperger's Syndrome: ☐
ADHD: ☐
Dyslexia: ☐
Dyspraxia: ☐
Learning Disability not listed: ☐
Please specify: ____________________

Lifestyle

Do you smoke? No ☐ Yes ☐ ______ /day Ex-Smoker ☐

Do you drink? No ☐ Yes ☐ ______ units/week

Weight: ____________________________ Height: ____________________________

Carers

Do you provide unpaid help or care to a relative, neighbour or friend who is unable to manage at home due to long term illness, age or disability? ☐

Are you cared for? ☐

If yes to either of the above, who do you care for or who cares for you?

Name:	
Telephone Number	
Relationship to you	
Reason for care given/received	

Would you like to speak to the practice's Carers' Champion? ☐

Would you like us to forward your details to the Vale of Glamorgan Carers Development Officer to add your name to the council carers' database. You will receive publications such As Caring Times and details of courses that are available in the area ☐

Communication preferences

I consent to text notifications being sent to me about appointment reminders, health promotion information, cancellation of clinics and information/changes in service provision Yes ☐ No ☐

I consent to e-mail notifications being sent to me about appointment reminders, health promotion information, cancellation of clinics and information/changes in service provision Yes ☐ No ☐

My Health Online Account

My Health Online offers patient the convenience to book appointments, order repeat prescriptions and change contact details all online. In the future you should be able to directly access information from your medical record including test results.

To protect patient confidentiality, you must provide photographic ID (e.g. driving license or passport) to verify your identification on application.

Please set up a My Health Online Account and issue me with a letter containing my account details ☐

Email Address for My Online Account: *Please write clearly*	

Signature: ____ Date: ______________

(Guardian's signature if the patient is under 16)

Please print and bring to the surgery with a completed GMS 1 form, your repeat prescription from your previous surgery (if applicable) and photographic ID (for My Health Online Account)