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Patient Information

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other _____ Gender: Male ☐ Female ☐

Forename: _____ Middle name: _____ Surname: _____

Date of Birth D D M M Y Y Y Y Confirm over 60 years of age: Yes ☐ No ☐ Surgery: _____

Contact Information

Home Tel: _____ Mobile Tel: _____ Work Tel: _____

email: _____

Which is your preferred contact method: Home Tel? ☐ Work Tel? ☐ Mobile Tel? ☐ Email? ☐

When would you prefer to be contacted: Between 9.00am and 12.00pm? ☐ Between 12.00pm and 3.00pm? ☐ Between 3.00pm and 6.00pm? ☐

I agree that Assura Pharmacy can contact me to remind me when it's time to order my repeat prescription ☐

Addresses

Home Address

Address 1: _____

Address 2: _____

Town: _____

Postcode: _____

Delivery Address - Is the delivery address the same as the home address?

Yes ☐ No ☐ If "no" please complete this section:

Address 1: _____

Address 2: _____

Town: _____

Postcode: _____

Agreement

I am the patient ☐ I am the patient's representative ☐ (A patient's representative is classified as either the parent/legal guardian, or in the case of incapable adults, a relative or other primary carer). I have read the terms and conditions and agree to be bound by them.

Name: _____ Signature: _____ Date: D D M M Y Y Y Y

For reasons of patient safety it will assist our pharmacist if you tell us of any conditions from which you may suffer.

Arthritis	☐	Depression	☐	Glaucoma	☐	High Blood Pressure	☐
Asthma	☐	Diabetes Mellitus	☐	Gout	☐	High Cholesterol	☐
Bronchitis/ Emphysema	☐	Eczema	☐	Hay Fever	☐	Irritable Bowel Syndrome	☐
Coeliac Disease	☐	Epilepsy	☐	Heart Disease	☐	Kidney Disease	☐

Liver Disease	☐						
Migraine	☐						
Psoriasis	☐						
Stomach Ulcer	☐						

Are you pregnant (or could you be)? Yes ☐ No ☐ Are you breast-feeding? Yes ☐ No ☐

Do you have any other medical conditions or drug allergies not included in the above list? If so, please tell us about them:

Surgery use only:
Scanned into patient file: ☐
Updated in EMIS: ☐

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