THE FROCESS MEDICAL CENTRE

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Dr S McCurdy, Dr H Armstrong, Dr A McCollum

Patient Registration Form

Please complete the following details and return this form to reception, along with your medical card. You will be registered with the practice and not with an individual GP. Please complete one registration form per person.

Mr/Mrs/Miss/Ms (delete as appropriate)

FIRST NAMES _____ **SURNAME** _____

CALLING NAME _____ **MAIDEN NAME** _____

ADDRESS _____ **D.O.B** _____

_____ **POSTCODE** _____

HOME TEL NO _____ **MOBILE TEL NO** _____

OCCUPATION _____ **WORK TEL NO** _____

TOWN OF BIRTH _____ **ETHNIC ORIGIN** _____
eg British, Irish, Chinese

PLEASE GIVE REASONS FOR WANTING TO JOIN THIS PRACTICE

_____

_____

NAME OTHER RELATIVES (IF ANY) REGISTERED AT THIS PRACTICE

_____

PREVIOUS DETAILS

ADDRESS _____ GP/PRACTICE _____

_____ ADDRESS _____

_____ PRACTICE TEL NO _____

PAST ILLNESSES (Please tick and give dates where possible)

Measles _____ Whooping Cough _____ Mumps _____ Jaundice _____

Chicken Pox _____Rheumatic Fever _____ German Measles _____Other _____

FAMILY HISTORY – OF ANY OF THE FOLLOWING CONDITIONS (If YES – Please record age of onset of condition)

		MOTHER/age	FATHER/age	BROTHER/age	SISTER/age
Heart Attack	Yes/No	_____	_____	_____	_____
Angina	Yes/No	_____	_____	_____	_____
High B/P	Yes/No	_____	_____	_____	_____
Stroke	Yes/No	_____	_____	_____	_____
Diabetes	Yes/No	_____	_____	_____	_____
Breast Cancer	Yes/No	_____	_____	_____	_____
Prostate Cancer	Yes/No	_____	_____	_____	_____
Stomach Cancer	Yes/No	_____	_____	_____	_____
Bowel Cancer	Yes/No	_____	_____	_____	_____

IMMUNISATION HISTORY – please tick if received and give dates (if possible)

Office Use Only **Date Received:**_____

Diptheria _____ Tetanus _____ Polio _____ Hib _____
MMR _____ Typhoid _____ Influenza _____
Rubella (German measles) _____ Pertussis (whooping cough) _____ Measles (single vacc) _____
Other _____

GENERAL (please circle appropriate response)

What operations have you had? _____

Private Health Care? Yes/No

Current Smoker, If yes how many per day? _____
Ex-smoker? Yes/No If you have stopped smoking when did you give up? _____
Never smoked? Yes/No

Do you drink alcohol? Yes/No If YES – how many units/drinks per week?
Wine _____ Beer _____ Spirits _____

Do you take Exercise? Yes/No If YES – what and how often _____ times per week?

Please note: the definition of a carer is someone who is in receipt of a carers allowance, or who is the main carer for an elderly or disabled person whose welfare may be at risk if the carer falls ill.)
Do you have a Carer? Yes/No ***or*** Are you a Carer for someone? Yes/No
If you have a carer can you please give us their:
Name _____ Address _____

Date of Birth _____ _____

Telephone number _____

Please list any allergies you have _____

Please describe any special diet you are on _____

Please list any medication you are currently taking: _____

_____

WOMEN ONLY (please circle appropriate response)
Are you taking the Oral Contraceptive Pill? Yes/No
Are you receiving Contraceptive Injection? Yes/No
Do you have a coil fitted? Yes/No If YES when & where was it fitted? _____
_____

Give date of last cervical smear _____ Where was it taken? _____

Have you any children? Yes/No If YES what ages _____
Have you had a HYSTERECTOMY? Yes/No If YES when & where_____

THANK YOU FOR COMPLETING THIS FORM

_____

FOR GP COMPLETION

Date of Registration Medical _____ Weight _____ Height _____
B/P _____ Pulse _____ Urinalysis: Glucose _____ Blood _____ Protein _____
Does this patient suffer from any of the following significant conditions?
CHD Yes/No Stroke Yes/No Hypertension Yes/No
COPD Yes/No Diabetes Yes/No Hypothyroidism Yes/No
Cancer Yes/No Epilepsy Yes/No Mental Health Yes/No Asthma Yes/No
If YES to any of the above please give details
_____
_____
Present Medication_____
_____

Doctor's Signature _____ Date _____

Office Use Only **Date Received:_____**