THE FROCESS MEDICAL CENTRE

56 Main Street, Cloughmills, Ballymena BT44 9LF
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Dr S McCurdy, Dr A McCollum & Dr B Logan

Patient Registration Form Date Received :

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)

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 list any allergies you have _____

Please describe any special diet you are on _____

Please list any medication you are currently taking:
_____

_____

Do you 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
_____
_____

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 list their details below:

Name _____ Address _____

Date of Birth _____ _____

Telephone number _____

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 : Medication list request from previous surgery date received:

Welcome date :

Medical Card/ HS200& ID /HSCR1 & ID provided:

Doctor's Signature _____ Date _____