Banchory Group Practice

NEW PATIENT REGISTRATION

Please try and answer as fully and as accurately as possible. This is our only medical record for our doctors and nurses to use until your notes arrive, which may take some months.

For information about the practice and our staff and services, pick up a patient information leaflet or visit www.banchorygrouppractice.co.uk

YOUR DETAILS

Name…………………………………………………………….. Mr/Mrs/Ms/other………………….

Date of Birth……………….. Occupation………………………..

ETHNIC ORIGIN: We are required by the NHS to record ethnic origin under the following categories. This is to ensure that the NHS provides equality of care for all. You do not have to give these details – please indicate below if you do not wish to.

☐	White Scottish	☐	Indian	☐	Black Caribbean
☐	Other white British	☐	Pakistani	☐	Black African
☐	White Irish	☐	Bangladeshi	☐	Other black
☐	Other white	☐	Chinese		
☐	Other ethnic, mixed	☐	Other Asian	☐	Other – please state ___________

☐ I do not wish to give this information

Address………………………………………………………………………………………………...

………………………………………………………….Postcode ………………………………………

Tel: Home ………………………. Work…………………….. Mobile ……………………………

Name and address of Practice you were registered with previously

………………………………………………………………………………………………………..

YOUR MEDICAL HISTORY

Please list any previous or current illnesses, accidents or operations

Condition/operation	**Year it occurred**

1…….

2…….

3…….

4…….

5…….

YOUR FAMILY HISTORY

Is there a history of significant illnesses in your family? E.g. heart problems, stroke, cancer, diabetes, dementia etc.

Who	Medical condition	Approx age when occurred (if known)

…….

…….

…….

…….

Do you take regular medicines/tablets? Please list the tablet name, strength and dose e.g. aspirin 75mg once daily

1………………………………………………………. **5……………………………………………………….**

2………………………………………………………. **6……………………………………………………….**

3………………………………………………………. **7……………………………………………………….**

4………………………………………………………. **8……………………………………………………….**

Are you allergic or sensitive to any drugs or other substances? If YES, please state the name of the drug and the nature of the reaction that occurred e.g. rash, swelling

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YOUR LIFESTYLE

☒ **Never Smoked Tobacco** ☒ **Ex smoker (date stopped)……..** ☒ **Current smoker per day …………**

☒ **Current drinker** ☒ **Ex drinker (date stopped) …….** ☒ **Lifetime teetotal**

How many of the following do you usually drink per week:

Pints of beer (2 units)……… Glasses of wine (1 unit) …….. Pub measures of spirits (1 unit) ………..

Do you know your weight? ……stones/lbs …….kg Do you know your height? …..ft/inch …….cm

Are you a carer? Yes ☒ No ☒

IF YES, PLEASE COMPLETE ADDITIONAL CARER FORM ATTACHED

FOR WOMEN ONLY:

What was the date of your last Cervical Smear? …………………………Result?……………..

If you have a contraceptive coil/implant in place Date inserted………………….. Date last checked………

Have you had a hysterectomy? Yes ☒ No ☒

Patient Signature ______________________________ Date ______________________________