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Dr. K. Cattanach
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PATIENT REGISTRATION QUESTIONNAIRE

You have joined our list and it may be some time before your records reach us. The absence of these records may impair the service which we would like to provide you with. In order to help overcome this problem, it is important that you **COMPLETE A QUESTIONNAIRE FOR EACH MEMBER OF YOUR FAMILY** registering with the practice.

ABOUT YOU		
FIRST NAME(S):	SURNAME:	
FORMER NAME(S):	MALE: [ ]	MARRIED: [ ] SINGLE: [ ]
DATE OF BIRTH:	FEMALE: [ ]	WIDOWED: [ ] DIVORCED: [ ] SEPARATED: [ ]
CURRENT ADDRESS:	PREVIOUS ADDRESS:	
CONTACT NUMBER(S):	EMAIL ADDRESS:	
PREVIOUS GP PRACTICE NAME:	OCCUPATION:	
PREVIOUS GP PRACTICE ADDRESS:	RECENTLY SERVED IN H.M. FORCES?	

WHAT ETHNIC GROUP DO YOU BELONG TO?		**Please note: You are not obligated to complete this section**					
White British	[ ]	Black British	[ ]	Chinese	[ ]	Indian	[ ]
Bangladeshi	[ ]	Pakistani	[ ]	Black African	[ ]	Black Caribbean	[ ]
Other (please specify): ___________________________________							

DO YOU HAVE A CARER?	**If you do, please provide details:**
NAME:	CONTACT NUMBER:
ADDRESS:	IS YOUR CARER A RELATIVE OR AN EMPLOYED CARER?:

YOUR HEALTH							
Do you suffer from, or have you ever suffered from, any of the following medical conditions?							
Diabetes	[ ]	Epilepsy	[ ]	Asthma	[ ]	Tuberculosis	[ ]
Jaundice	[ ]	Stroke	[ ]	Angina	[ ]	High Blood Pressure	[ ]
Heart Attack	[ ]	COPD	[ ]	Atrial Fibrillation	[ ]	Peripheral vascular Disease (PVD)	[ ]

Do you have any problems with your:									
Eyes	[ ]	Stomach	[ ]	Chest	[ ]	Nerves	[ ]	Thyroid	[ ]
Further information:									

Have you ever had any major operations / serious illnesses?	
OPERATIONS	**SERIOUS ILLNESSES**

Are you taking any medications regularly? (Whether subscribed by your Doctor or not)		
NAME OF DRUG	**STRENGTH**	**HOW OFTEN**

Are you allergic to any medicines / drugs?	
MEDICINE / DRUG NAME	**REACTION EXPERIENCED**

HEALTH PROMOTIONS	
SMOKING HABITS:	
Current Smoker [ ]	How many per day?
Ex Smoker [ ]	How many did you smoke per day?
Never Smoked [ ]	What date did you stop smoking?
ALCOHOL CONSUMPTION: Please estimate your alcohol intake	
No of units per week:	1 unit = ½ pint of beer, 1 glass of wine, 1 pub measure of spirit (25ml)
GENERAL HEALTH:	
Height:	Weight:

FAMILY HEALTH HISTORY	
AGE & STATE OF HEALTH	**AGE & CAUSE OF DEATH**
MOTHER:	MOTHER:
FATHER:	FATHER:
BROTHER(S):	BROTHER(S):
SISTER(S):	SISTER(S):
Are there any hereditary diseases in your family? e.g. Glaucoma, Cystic Fibrosis	

WOMEN'S HEALTH			
PREGNANCY & CHILDREN:		**COIL / IMPLANON:**	
How many pregnancies have you had?		Do you have a coil / implanon fitted?	
		Yes [ ]	No [ ]
		If yes, date of the last check up:	
Have any ended in: Miscarriage ______ Termination ______ Stillbirth ______	Dates of birth of children: 1st 2nd 3rd 4th	**CERVICAL SMEAR:**	
		Have you ever had a cervical smear?	
		Yes [ ]	No [ ]
		If yes, date of last smear?	
		What was the result of this smear?	

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CONSENT TO REQUEST MEDICAL SUMMARY FROM PREVIOUS GP PRACTICE

I, ____ , give my consent for The Maryhill Group Practice to contact my previous GP Surgery, ____, to request a patient summary as I have now registered at The Maryhill Group Practice as a permanent patient.

Signed: ____

Print: ____

Date of Birth: ____

Date: ____