

Dr. R. Lockhart
 Dr. K. Cattanach
 Dr. G. Taylor
 Dr. V. Thomson
 Dr. A. Macgregor



Tel: 03453 370 610
 Fax: 01343 551 604

Elgin Health Centre, Maryhill, Elgin, IV30 1AT
Roths Medical Centre, High Street, Roths, AB38 7AT
E-mail: gram.maryhillhcelgin@nhs.scot
W: www.elginhealthcentre.co.uk

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: <input type="checkbox"/> MARRIED: <input type="checkbox"/> SINGLE: <input type="checkbox"/> FEMALE: <input type="checkbox"/> WIDOWED: <input type="checkbox"/> DIVORCED: <input type="checkbox"/> SEPARATED: <input type="checkbox"/>
DATE OF BIRTH:	
CURRENT ADDRESS:	PREVIOUS ADDRESS:
CONTACT NUMBER(S):	EMAIL ADDRESS:
PREVIOUS GP PRACTICE NAME:	OCCUPATION:
PREVIOUS GP PRACTICE ADDRESS:	RECENTLY SERVED IN H.M. FORCES?
HAVE YOU BEEN REGISTERED WITH US OR RECEIVED TREATMENT FROM US BEFORE?	
WHAT ETHNIC GROUP DO YOU BELONG TO?	Please note: You are not obligated to complete this section
White British <input type="checkbox"/> Black British <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/>	
Bangladeshi <input type="checkbox"/> Pakistani <input type="checkbox"/> Black African <input type="checkbox"/> Black Caribbean <input type="checkbox"/>	
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:	
How many pregnancies have you had?	COIL / IMPLANON:
	Do you have a coil / implanon fitted?
	Yes [] No []
	If yes, date of the last check up:
Have any ended in:	CERVICAL SMEAR:
Miscarriage _____	1 st
Termination _____	2 nd
Stillbirth _____	3 rd
	4 th
	Have you ever had a cervical smear?
	Yes [] No []
	If yes, date of last smear?
	What was the result of this smear?

PATIENT SERVICES (VISION ONLINE)

Do you wish to be registered for Patient Services? This will allow you to order repeat medication online rather than submitting paper copies of your repeat slip to the practice or your local pharmacy. If you do, please complete the section below.

EMAIL ADDRESS: **PREFERRED PHARMACY (where your prescriptions will be sent)**

Boots High Street	<input type="checkbox"/>	Boots Glassgreen	<input type="checkbox"/>	Boots Springfield	<input type="checkbox"/>	Bishopmill	<input type="checkbox"/>
Right's Lossie Clifton Road	<input type="checkbox"/>	Right's Lossie Queen Street	<input type="checkbox"/>	Burghead / Hopeman	<input type="checkbox"/>	Baird's Westend	<input type="checkbox"/>
Roths	<input type="checkbox"/>	Aberlour	<input type="checkbox"/>	Lhanbryde	<input type="checkbox"/>	Collect at Elgin Health Centre	<input type="checkbox"/>

We do not deal with Christies of Fochabers pharmacy. If you would like to arrange for prescriptions to be sent there, you will need to provide us with your own stamped addressed envelopes made out to Christies of Fochabers chemist. Thank you.

Dr. R. Lockhart
Dr. K. Cattanach
Dr. G. Taylor
Dr. V. Thomson
Dr. A. Macgregor



Tel: 03453 370 610
Fax: 01343 551 604

*Elgin Health Centre, Maryhill, Elgin, IV30 1AT
Rothes Medical Centre, High Street, Rothes, AB38 7AT
E-mail: gram.maryhillhcelgin@nhs.scot
W: www.elginhealthcentre.co.uk*

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: _____