Today's Date ………………………………

CONFIDENTIAL **(FEMALE)**

WELCOME TO DANESTONE MEDICAL PRACTICE

Please complete all the questions on this two sided questionnaire.
If you are on regular medication please make an introductory appointment with a Doctor.

HAVE YOU EVER BEEN REGISTERED WITH THIS PRACTICE IN THE PAST? YES/NO

SURNAME______________________________**FORENAMES** ____

MRS/MISS/MS/TITLE:______**PREVIOUS SURNAME**________________**DATE OF BIRTH** ___________________

ADDRESS(inc POSTCODE)____

HOME TEL ________________**WORK TEL** ____________________**MOBILE NO** _____________________________

Please tick here if you DO NOT wish to be contacted using your mobile phone number – including by text ☐

EMERGENCY CONTACT NO: _________________ **NEXT OF KIN (Name & contact number)**__________________

SINGLE/MARRIED/CIVIL PARTNERSHIP/SEPARATED/DIVORCED/WIDOWED/OTHER____________

OCCUPATION ________________

ARE YOU A CARER FOR A RELATIVE? _____________ **IF YES, PLEASE GIVE DETAILS** _____________________

DO YOU HAVE A RELATIVE WHO IS YOUR CARER?________ **IF YES, PLEASE GIVE DETAILS**_________________

MAY WE RECORD CARER INFORMATION IN YOUR MEDICAL RECORDS? _________________________________

YOUR PREVIOUS ADDRESS____

NAME AND ADDRESS OF YOUR PREVIOUS GP ____

Have you had any serious illnesses/operations/pregnancies?

DATE	Hospital (if applicable)	Illness/operation/pregnancy with names of children

Do you have any medical problems at the moment? ____

Please list any allergies ____

DOES ANYONE IN YOUR FAMILY SUFFER FROM THE FOLLOWING: (IF 'YES' PLEASE GIVE DETAILS)

• **Diabetes**	**NO / YES (Family Member:____________________)**
• **High Blood Pressure**	**NO / YES (Family Member:____________________)**
• **Heart Disease (under 60yrs)**	**NO / YES (Family Member:____________________)**
• **Heart Disease (over 60 yrs)**	**NO / YES (Family Member:____________________)**
• **Asthma**	**NO / YES (Family Member:____________________)**
• **Stroke/Brain Haemorrhage**	**NO / YES (Family Member:____________________)**
• **Cancer - Breast; Bowel; Cervical; Ovarian; Lung; Prostate; Skin**	**NO / YES (Family Member:_____________________)** **(Type of cancer:_____________________)**

PLEASE TURN QUESTIONNAIRE OVER

Are you taking any tablets, the contraceptive pill, medicines, etc (including those bought from a chemist)? IF YOU HAVE BEEN RECEIVING REPEAT PRESCRIPTIONS FROM YOUR PREVIOUS GP, PLEASE ATTACH A REPEAT PRESCRIPTION SLIP

Name of Drug	Strength	How often taken

PLEASE NOTE THAT NO REPEAT PRESCRIPTIONS CAN BE ISSUED UNTIL YOU HAVE SEEN ONE OF OUR DOCTORS for your new patient medical

HAVE YOU EVER SMOKED? ___________ HOW MUCH PER DAY? __________ CIGARETTES/CIGARS/PIPE
DO YOU SMOKE NOW? _______________ HOW MUCH PER DAY? __________ CIGARETTES/CIGARS/PIPE
WHEN DID YOU STOP SMOKING? ____________

DO YOU DRINK ALCOHOL? ____________________________ HOW MUCH PER WEEK? ____________________

WHAT EXERCISE DO YOU TAKE? ____
HOW OFTEN? ____

WHAT IS YOUR HEIGHT? ______________________________ WHAT IS YOUR WEIGHT? _____________________

HAVE YOU HAD A CERVICAL SMEAR TEST? ____

WHEN WAS YOUR LAST TEST? ______________________ WHERE WAS THE TEST TAKEN? ________________

(FOR WOMEN PLANNING TO BECOME PREGNANT ONLY)
Have you had your rubella vaccination checked by a blood test? _____ If not, please make an appointment with the Practice Nurse for a blood test

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

- ☐ I do not wish to give this information

Do you use an interpreter? YES/NO If "YES" which language? ___________________

Signed _________________________________ Name _______________________________Date __________

Thank you for taking the time to complete this form for us.

DR DAMIAN MCGRORY DR RHONA McKEOWN
DR KEVIN CORMACK DR LINZI LUMSDEN

ADMIN USE ONLY ID CHECK
Initials:
Forms of ID verified:
1)
2)

If you have had a cervical smear in the past please complete the form below to make sure you are included in the Grampian Recall system. If you are not sure whether this applies to you please ask at Reception when you bring in your registration forms.

PRACTITIONER SERVICES **P.T.I.**

PATIENT TRANSFER INFORMATION - CERVICAL SMEARS

NAME AND ADDRESS OF DOCTOR:

Ref No.:

SURNAME...
(Mrs. Ms. Miss)

FORENAMES ....

DOB/CHI...

ADDRESS ....

....

.... **POSTCODE**..............

DATE REGISTERED ....

PREVIOUS GP..

PREVIOUS AREA ....

THE PATIENT NAMED ABOVE HAS RECENTLY TRANSFERRED INTO GRAMPIAN AREA DETAILS OF PAST CERVICAL SMEARS ARE AS FOLLOWS

CERVICAL SMEARS (within last $5^{1}/_{2}$ years) (complete back to last GP date only)

DATE OF SMEAR	Source of smear GP, Gyne, Hospital, F/Plan etc	RESULT IF KNOWN

* Confirmed verbally / by document

PLEASE INDICATE IF THE PATIENT HAS HAD A COMPLETE HYSTERECTOMY (requring no further smears)

* Delete where appropriate YES / NO

** SIGNATURE: GP:
PATIENT:
DATE:

** If confirmed verbally, patient should sign.
If confirmed by sight of documents the GP should sign.

NOTE:
Please submit this form attached to Registration document (Medical Card / GPR)