MCHUGH-CAMPBELL PRACTICE – PATIENT REGISTRATION FORM

Please answer ALL questions. The information provided will form part of your medical record.

PERSONAL DETAILS

1. MR MRS MISS MS

2. Surname:_____

3 First name: _____

4 Previous surname: _____

5 Male Female

6 Date of Birth: _____

7 H&C No: _____

8 Town and
Country of birth: _____

9 If you are from abroad,
The date you came to UK: _____

10 Current Address:_____

_____

Post Code: _____

11 How long will you be at this address?
Less than 6 mths More than 6 mths

12 Home telephone no: _____

13 Work telephone no: _____

14 Mobile No: _____

15 E-Mail: _____

PREVIOUS GP DETAILS

16 Have you ever been registers with a GP in the UK? Yes No

17 Name and address of last GP/Surgery: _____

YOUR NEXT OF KIN/EMERGENCY CONTACT

Next of kin's name: _____

23 Next of kin's address: _____

_____

Relationship to you: _____

24 Telephone number: _____

SIGNIFICANT ILLNESSES/CONDITIONS (please tick and give date first diagnosed)

Diabetes
Heart Disease
COPD
Thyroid Problems
Any other illness
Stroke (CVA)
Asthma
Depression
Cancer

HAVE YOU HAD ANY OPERATIONS? (please give details)

DRUGS & MEDICINES (please tick relevant boxes

Are you being prescribed medication on a repeat basis? Yes ☐ No ☐

Please list all medication you are currently taking:

Are you **ALLERGIC** to any medication? Yes ☐ No ☐ if yes please state: ……. …….

YOUR ETHNIC GROUP
Please choose one of the five sections and then tick your ethnic group
(Please tick **one** box only) These ethnic group description are a national standard taken from the 2001 census

LANGUAGE

My main spoken language is _____ (one only)

White
White British ☐

White Irish ☐

Other White- please state: _____

Other (Please specify):

LIFESTYLE

Do you smoke? **Yes / No** How many:

For Ex smokers Date Quit

How often do you have a drink containing alcohol?

Never Monthly or less 2 – 4 times per month 2 – 3 times per week

4 + times per week Daily

FOR WOMEN ONLY

Date of last cervical smear: _____

Signature of patient: _____ Date:_____