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 POSTODE)_____

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

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 ..... DATE REGISTERED .....

..... PREVIOUS GP.....

..... POSTCODE..... 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: DATE:
PATIENT:

** 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)