



WELCOME TO OUR PRACTICE

In line with Health Board recommendations, it is our practice to perform a health check on all new patients as this gives us an opportunity to find out about your past and present health. To register with us, you will need this completed and signed form with:

- **Two forms of ID** - one with a photo (passport, driving licence) and one proving your address in our practice area (utility bill, rental agreement, bank statement etc).
- Birth certificate or passport for children or the white NHS form for new babies (supplied by registrar when registering the birth).

Once we have your details, you will be invited to attend a New Patient Health Check (only necessary for patients over 5 years old).

Office Use Only - TWO FORMS OF ID CHECKED:		Initials:		Date:	
Details:	1.	2.			
NPR appt:				Sample bottle given <input type="checkbox"/> (over 16's only)	

PERSONAL DETAILS

Have you ever been registered with this practice before? Y N

Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other _____		DOB:	
Name:		Home tel:	
Address:		Mobile tel:	
		Work tel:	
Postcode:			

Occupation: Single Married Civil Partnership
 Separated Divorced Widowed

Previous home address:	Previous Medical Practice/Surgery name & address:

PLEASE BRING URINE SAMPLE TO REGISTRATION APPOINTMENT (OVER 16YRS ONLY)

Next of Kin name:			
Relationship:			
Contact numbers for Next of Kin:		Mobile:	
Work:		Home:	

In the past week, on how many days have been physically active for a total of 30 minutes or more?							
<i>Physical activity may include: walking or cycling for recreation or to get to and from places; gardening; and exercise and sport which lasts for at least 10 minutes.</i>							
0	1	2	3	4	5	6	7

Allergies: (eg hayfever)	
Medicine Allergies: (eg penicillin)	

Immunisations History	
As a child:	
At school:	
For travel:	

WOMEN ONLY		
Have you ever had a cervical smear?		Y <input type="checkbox"/> N <input type="checkbox"/>
When? (year at least)	Where? GP/FPC/Chalmers/Hospital/Overseas	
Result? Normal/Early Recall/Colposcopy	Have you ever had breast screening Y <input type="checkbox"/> N <input type="checkbox"/>	

Do you look after a relative, partner or friend who needs support because of age, physical or learning disability or illness, including mental ill health?	Y <input type="checkbox"/> N <input type="checkbox"/>
If Yes, who do you care for?	
Name:	
Address:	

Parent(s) of children aged 0-16 years:	
Has you child ever been on the Child Protection (At Risk Register) at any time?	Y <input type="checkbox"/> N <input type="checkbox"/>
Does your child/family have any social work involvement?	Y <input type="checkbox"/> N <input type="checkbox"/>
Does your child have a learning disability?	Y <input type="checkbox"/> N <input type="checkbox"/>

Have you had any contact with Drug Agencies?	Y <input type="checkbox"/> N <input type="checkbox"/>
--	---

Have you had any contact with Social Care?	Y <input type="checkbox"/> N <input type="checkbox"/>
--	---

From 1st April 2006 we are obliged to record Ethnicity. Please tick the appropriate box.

White Scottish Other White British Other White Ethnic Other Ethnic, mixed origin

Indian Pakistani Bangladeshi Chinese

Other Asian ethnic group Black Caribbean Black African Other Black ethnic group

Other ethnic group Please tick this box if you decline to answer

Thank you for completing this questionnaire. Please sign and date below, and arrange your health check appointment with reception if you wish to have one.

Signed:

Date:

OFFICE USE ONLY

Health check appointment booked: Y N

GP appointment: Y N Dr: _____ Date: _____

BP: _____ Weight: _____ Height: _____ Urine: alb _____ gluc _____

Date form processed: _____ Initials: _____