DR. A.R. McKAY
DR. R.J.G. STEWART
DR. A.S.M. SNEDDON
DR. D.O. COOPER
DR. N.C.R. GRANT
DR. D.J. WEARDEN
DR. J.E. VORENKAMP
DR. C.G. BEATTIE
DR. B.U. OKPO
DR. J. GRAY

THE OLD MACHAR MEDICAL PRACTICE

526 KING STREET
ABERDEEN
AB24 5RS
Tel 0845 337 0510
Fax 01224 846 999

JESMOND DRIVE
BRIDGE OF DON
ABERDEEN
AB22 8UR
Tel 0845 337 0510
Fax 01224 846 600

PLEASE READ THE FOLLOWING VERY CAREFULLY BEFORE COMPLETING AND RETURNING YOUR REGISTRATION FORMS

Please fill in **ALL** sections of both forms you have been given, **INCLUDING** your previous address, previous GP and town of birth. (This is required by the Practitioner Services Health Board in order to trace your previous medical records and MUST be provded).

ALL patients are requires to provide **PHOTOGRAPHIC ID**, either a Passport or Driving Licence with photograph, when returning forms to the Surgery. You must also provide some form of paperwork showing your current address, i.e. bank statement, utility bill, council tax.

As photographic ID is a requirement, where possible we ask that **ALL** those wishing to register bring their Registration Forms to the Surgery in **PERSON**.

If you wish to register children with the Practice, we ask that you provide their Birth Certificate along with their Registrations Forms, and if possible the children should accompany you.

We are open until 8:00pm most Monday evenings if you are unable to come in between the hours of 8:00am and 6:00pm.

We look forward to welcoming you to the Old Machar Medical Pracitce and hope the above will help to make your registration with us as simple and quick as possible.

Thank you.

OLD MACHAR MEDICAL PRACTICE

PATIENT REGISTRATION QUESTIONNAIRE

Please complete this form using BLOCK CAPITALS **Please complete ALL SECTIONS of this form (if applicable)**

REGISTRATION DETAILS

Sex ☐ Male ☐ Female

Title – *Mr, Mrs, Miss, Ms, Dr, Prof, Other*

First Name

Middle Name(s)

Surname

Date of Birth – *DD MM YYYY*

Place and Country of Birth

Current Address

Postcode

Home Telephone Number

Work Telephone Number

Mobile Telephone Number

E-mail Address

Name of Next of Kin

Relationship to you

Contact Telephone Number

Occupation

University/College Course *(if applicable)*

How long have you been, or will you be, doing this?

ETHNICITY

☐ Scottish
☐ Other British
☐ Irish
☐ Gypsy/Traveller
☐ Polish
☐ Other White Ethnic Group
☐ Pakistani, Paskistani Scottish or Pakistani British
☐ Indian, Indian Scottish or Indian British
☐ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
☐ Chinese, Chinese Scottish or Chinese British
☐ Other Asian Background
☐ African, African Scottish or African British
☐ Carribbean, Carribean Scottish or Carribean British
☐ Black, Black Scottish or Black British
☐ Arab, Arab Scottish or Arab British
☐ Other ethnic group – *please specify in box below*

☐ Interpreter needed – *specify language/sign language*

SOCIAL AND FAMILY DETAILS

Do you look after someone? ☐ Yes ☐ No What is your relationship to them?

Does someone look after you? ☐ Yes ☐ No What is your relationship to them?

MEDICAL HISTORY

Please list all current and previous illnesses, operation and accidents

Date	Problem	Date	Problem

MEDICATIONS

Please list all current medications or include a repeat medication list from your previous GP

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

ALLERGIES

Medication Name	Reaction	Medication Name	Reaction

LIFESTYLE

ALCOHOL

How many units of alcohol do you drink weekly? (1 unit = ½ pint of beer, small glass of wine or a small measure of spirit)

- ☐ Non-drinker/Tee total
- ☐ < 7 units
- ☐ 7-14
- ☐ 15-21 units
- ☐ 22-35 units

SMOKING

- ☐ Never Smoked
- ☐ Ex-smoker

Date stopped ______

- ☐ Current smoker

Number Smoked Daily ______

If you would like help to stop smoking please speak to a GP or Nurse or phone the smoking advice service on 0500 600 332

EXERCISE

- ☐ Exercise physically impossible
- ☐ Avoid even trivial exercise
- ☐ Enjoy light exercise
- ☐ Enjoy moderate exercise
- ☐ Enjoy heavy exercise

CONTRACEPTION

☐ Pill *(combined or progesterone only)*

Name of Pill ______

☐ Patch

Name of Patch ______

☐ Implant *(Implanon/Nexplanon)*

Date Inserted ______

☐ Coil *(Mirena/Copper IUD)*

Date Inserted ______

☐ Female Sterilisation

☐ Vasectomy *(Male Sterilisation)*

CERVICAL SMEAR

Date of last smear ______ Result of last smear ______

Last smear taken at: ☐ GP Surgery ☐ Hospital ☐ Family Planning Clinic

HEIGHT AND WEIGHT

Approximate Height ______ Approximate Weight ______

Patient Signature: ____________________________________ Date of form completion: ____________________