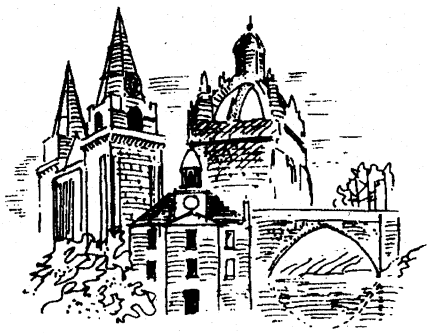
DR. A.R. McKAY
DR. R.J.G. STEWART
DR. D.O. COOPER
DR. N.C.R. GRANT
DR. D.J. WEARDEN
DR. C.G. BEATTIE
DR. J. GRAY
DR. B.U. OKPO
DR. S.A.M. BRUCE
DR. J.P. KILBY
DR. S.D. TAYLOR
DR. L.H. THOMSON



THE OLD MACHAR MEDICAL PRACTICE

526 KING STREET
ABERDEEN
AB24 5RS
Tel 0345 337 0510
Fax 01224 661 670

JESMOND DRIVE
BRIDGE OF DON
ABERDEEN AB22 8UR
Tel 0345 337 0510
Fax 01224 661 670

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

- Please **complete all sections of both forms.**

- It is important that you **include your previous address, previous GP and the town of birth** so that the Practitioner Service Division of NHS Grampian can correctly identify you and locate your previous medical records.

  If you have any problems completing the forms, please contact a member of the reception team who will be happy to help you.

- **ALL** patients are required to provide **TWO** types of identification at registration.
  1. **PHOTOGRAPHIC ID** – For example a Passport or Driving Licence. If you are unable to provide photographic ID; a Birth Certificate is required.
  2. **PROOF OF ADDESS** – For example a utility bill, lease agreement or bank statement.

- It is essential that everyone registering with the practice is present at registration. This also applies to any children registering.

- If you are taking regular medication(s) please provide your list of medications, preferably the right-hand side of your prescription from your previous practice. This should prevent any delays when you need to order further supplies.

We look forward to you joining Old Machar Medical Practice and hope that the above will assist in making the registration process as simple and quick as possible.

Please see the Practice website www.oldmachar.co.uk for further information about the practice and the services that we provide.

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: _____