

# Welcome to The Pentlands Medical Centre

## New Patient Registration Form

Welcome to The Pentlands Medical Centre. In order for us to provide you with the most appropriate care we would be grateful if you would complete and return the attached questionnaire along with the following documents.

1. **NHS Medical Card (1<sup>st</sup> choice and alternative to photo ID)**
2. **Birth Certificate accompanied by photographic ID. (passport, ID card or driving licence)\***
3. **Proof of address\* (i.e. Mortgage/rental agreement, utility bill within the last 6 months, bank statement, current employment documents.**

If proof of address is not available then 2 out of 3 of the above must be provided and one must be photographic ID.

It is important that you have a **registration appointment** as it will give us the chance to tell you a bit about the practice and enable you to give us brief details of your medical history until your health information is sent to us from your previous practice.

At your appointment we will check your blood pressure, record your height and weight and other important information about your health.

**It is also important that we establish your 'Right to NHS Treatment', before you join the practice, and in order to do this we ask that you supply us with documentation such as a passport or working visa.**

If you are a spouse of someone who has a working visa you will be asked to provide a marriage certificate or proof of co-habitation before your registration will be accepted. Children under 16 are covered by a parent's application.

If you are unable to provide the required documentation you will not be allowed to register at this practice under the National Health Service and you will be required to pay for any consultation / treatment you receive. If you require further information regarding your 'Right to NHS Treatment' please ask at reception. Alternatively you can access the most up to date information by visiting our website at [www.pentlandsmc.co.uk](http://www.pentlandsmc.co.uk).

Name :	Please select: Mr. Mrs. Miss.	Tel. No. Home	
		Work	
Address		Occupation	
		Postcode	
Date of Birth		Country of Birth	

**GENERAL HISTORY** Have you ever suffered from any of the following:

Heart attack or Angina	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Stomach Diseases	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke or Ministroke	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney / Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Gynaecological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other Chest or Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mental / Nervous Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Other Significant illness (please specify).....

Have you had any operations? Yes  No

If yes please specify.....

Do you have any allergies to drugs or anything else? Yes  No

If so, please specify .....

Are you on any regular medication (including contraception)? Yes  No

If yes, please give details .....

.....

**FAMILY HISTORY**

1. Have any of the following relatives - mother, father, brother, sister had

A heart attack below the age of 60	Yes <input type="checkbox"/>	No <input type="checkbox"/>	A stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>
A heart attack above the age of 60 (Hyperlipidaemia)	<input type="checkbox"/>	<input type="checkbox"/>	Very high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>

VACCINATIONS

Which of the following immunisations have you had and in which year?

	Yes	Year	No	Don't know
Full course of childhood immunisations	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus Booster	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	.....	<input type="checkbox"/>	<input type="checkbox"/>

Others (please specify).....

<b>For Female Patients only</b>	
2. Have you ever had a cervical smear	Yes No
If yes – When was your last smear	.....
Have you ever had an abnormal smear	Yes No
Have you ever attended a colposcopy clinic	Yes No
Have you had a hysterectomy	Yes No
If yes - please give date	.....

**Smoking Status**

Never Smoked Tobacco

Ex Smoker  Date Stopped

Current Smoker

**You will be aware that smoking may have an adverse effect on your health. We have nurse run smoking cessation clinics at the surgery. If you are interested in stopping smoking please arrange an appointment at reception.**

**Blood Pressure**

Guidelines from Lothian Health Board advise that patients over the age of 45 have their blood pressure checked once every 5 years. If you have not had this done you can make an appointment with the practice nurse to do so. If you are unsure of the last time you had your blood pressure taken, please ask at reception and staff will be able to give you this information.

**Alcohol Consumption**

The recommended weekly alcohol units are 14 for female and 21 for male. Please state below what you think your **average weekly alcohol intake** is based on the following guidelines.

- 1 Pint medium strength beer 2.8 units
- 1 **Small** glass wine (11%) 1.4 units
- 1 single measure of spirit 1.4 units

None  1 – 7  8-14  15 -21  22 –30  +31