Drs Miller, Anderson and Fleming

New patient registration form for over 16 year olds

Please complete all the following details and tick/circle the shaded boxes. This information will be treated in strictest confidence.

|  |  |  |
| --- | --- | --- |
| Patient Name |  | |
| Address |  | |
| Date of birth |  | |
| Ethnic status |  | |
| Language spoken |  | |
| Do you require an interpreter ? (please tick) | YES | NO |

|  |  |
| --- | --- |
| Next Of Kin |  |
| Phone Number |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you suffer from ...  (please tick) | Asthma | Heart disease | Diabetes | High blood  pressure |
| Epilepsy | Stroke | COPD |
| Other Medical problems |  | | | |
| Family history |  | | | |
| Current medications |  | | | |
| Allergies (please list) |  | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Immunisations up to date (please tick) | YES | | NO | |
| Cervical smears up to date (if applicable) | YES | NO | | NOT SURE |
| Result of last smear | NORMAL | ABNORMAL | |  |
| Smoking (please tick) | SMOKER | EX- SMOKER | | NEVER SMOKED |
| Alcohol (how many drinks a week) |  | | | |

**Due to new GDPR regulations we require written consent for someone else to collect your prescriptions. Please provide the names of anyone you give consent to collect your prescriptions below and then sign**

|  |
| --- |
| Sign Date |