STONEHAVEN MEDICAL GROUP
NEW PATIENT REGISTRATION

You have requested to join our practice and it may be some time before your medical records reach us. To help us provide the best service we can please complete this questionnaire which will become part of your medical record.

PERSONAL DETAILS

Surname:	**Forenames:**	**Date of Birth:**
Present Address: **Post Code:**	**Marital Status:** Single Married Widowed Separated Divorced Other	**Contact Telephone Numbers:** Home……..……..Mobile……... Work……..Other…….…..……. Can we contact you by text message with appt reminders, etc? Yes / No
Please indicate your preferred pharmacy with a tick in the box:	Charles Michie, 24 Market Square, Stonehaven AB39 2BE ☐	Boots The Chemist, 2-6 Evan Street, Stonehaven AB39 2EQ ☐
Next of Kin:	**Relationship to you and their Contact Telephone Number**	
Are you a Carer for someone? Yes/No (If yes, please give details)	**Do you have a Carer? Yes/No** (If yes, please give details)	

Height:	**Weight:**	**Are you allergic to any medicine?**	**Other known Allergies:**

Which ethnic group do you belong to? (please tick one box)				
White			**Mixed**	
Black or Black British			**Chinese**	
Asian or Asian British			**Other Ethnic Group**	

LIFESTYLE

SMOKING STATUS:		**EXERCISE:**		**ALCOHOL INTAKE- What is your average weekly consumption?** (1 unit =1/2 beer or 1 glass wine or 1 measure of spirits)	
Never Smoked		**Physically impossible**		**Tee-total**	
Current Smoker		**None**		**Average intake less than 21 units weekly**	
How many per day?		**Light Exercise**		**Average intake 21 – 28 units weekly**	
Ex Smoker		**Moderate exercise**		**Average intake more than 28 units weekly**	
Date Stopped:		**Heavy Exercise**			

FAMILY HISTORY – Have your parents, brothers or sisters had:- **(If yes please tick box and state which relative)**

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Heart Disease < 60 years (IHD)			**Stroke (CVA)**			**Diabetes**		
Heart Disease > 60 years (IHD)			**High blood pressure (Hypertension)**			**Asthma**		

WOMEN PATIENTS

		Yes	**No**	
Pregnancies: **Year and outcome**	**Have you had a mammogram?** If yes when…… **Are you taking Contraceptive Pill?** **Have you IUCD (coil) in place?** If yes which one and when inserted **Are you using another form of contraception?**			**Have you had a Cervical Smear?** **When?** **By GP Practice?** **Result?** **Never Had Smear – Would you like one?** **Yes / No**

Please Turn Over Page

Do you suffer from any of the following: (Please tick)

	Yes	No
Heart Disease		
Hypertension / High Blood Pressure		
Atrial Fibrillation		
History of Stroke / CVA		
Diabetes		
Chronic Kidney Disease		
Asthma		
Chronic Lung Disease / COPD		
Cancer		
Hypothyroidism		
Epilepsy		
Mental Health Problems		

HEALTH HISTORY: Have you had any other illnesses, accidents, operations (not including trivial illness such as colds, flu)? If yes please list below with year they occurred and hospital if abroad.

Year	Condition/Operation

MEDICATION:

Are you taking any tablets, medicines or inhalers at present? Yes/No If yes what are they?

CHILDREN'S IMMUNISATIONS: Please give dates and whether done by GP

	Diphtheria	Tetanus	Pertussis	Polio	MMR	HIB	Men C	Others (Please State)	Done By?
1st									
2nd									
3rd									
Booster									

OTHER IMMUNISATIONS: (Please give dates if you have had any immunisations)

Tetanus	Polio	Rubella	Influenza	Pneumovac	Any others (Please State)

HEALTH PROMOTION

If you require advice/leaflets on any of the following please tick box or ask reception:-

Anti-smoking		**Exercise**		**Cholesterol**		**Diet**		**Other**	

Signature of Patient …….…….…….……. Date ……..……..…