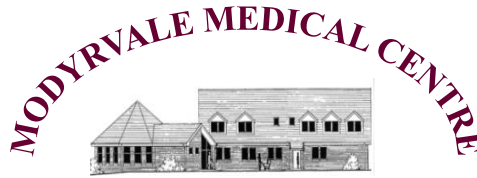


DATE:

Practice ID:



PATIENT QUESTIONNAIRE

Patients over 18 registering with the Practice will require an appointment with our Practice Nurse. This will be arranged by one of our reception staff. To assist us in processing your registration, **please arrive 10 minutes prior to your appointment time.**

Please note that failure to attend, or late arrival, without advance notification will result in you not being able to register with the Practice. Please initial this box to confirm that you have read/understood this:
 Please bring photographic ID and a urine sample to your appointment.

HAVE YOU PREVIOUSLY BEEN REGISTERED WITH THIS GP PRACTICE?	YES	NO	If yes, why did you leave?
	<input type="checkbox"/>	<input type="checkbox"/>	

NAME:		DATE OF BIRTH:				
ADDRESS:		HOME TEL NO:				
		MOBILE TEL NO:				
		OCCUPATION:				
NEXT OF KIN:		THEIR CONTACT TEL NO:				
ETHNIC ORIGIN	WHITE <input type="checkbox"/>	BLACK <input type="checkbox"/>	ASIAN <input type="checkbox"/>	CHINESE <input type="checkbox"/>	MIXED <input type="checkbox"/>	OTHER <input type="checkbox"/>
MARITAL STATUS			MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>

Please answer/provide details on the following:

1. Who lives at home with you?
2. Current illnesses:
3. Current medication:
4. Past illnesses:
5. Hospital admissions/previous operations:
6. Allergies:
7. Do you smoke?

YES	Never smoked	Ex-smoker	If yes how many a day?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Do you drink alcohol

YES	NO	If yes how many units per week?
<input type="checkbox"/>	<input type="checkbox"/>	
9. Do you take recreational drugs?

YES	NO	If yes please provide details.
<input type="checkbox"/>	<input type="checkbox"/>	
10. Reason for applying for registration with this Practice.

Continued, please turn over.....

Family medical history:	Diabetes	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
	Hypertension	<input type="checkbox"/>	Other

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Ladies:	Number of children:.....
	Date of last smear: Due Smear:

Details of children under 5				
1	Name.....	Date of Birth		
	Immunisations:	1st	<input type="checkbox"/>	Pre-school booster:
		2nd	<input type="checkbox"/>	<input type="checkbox"/>
		3rd	<input type="checkbox"/>	
2	Name.....	Date of Birth		
	Immunisations:	1st	<input type="checkbox"/>	Pre-school booster:
		2nd	<input type="checkbox"/>	<input type="checkbox"/>
		3rd	<input type="checkbox"/>	

Where you live:	YES	<input type="checkbox"/>
I confirm that my current address is within the Practice boundary.	NO	<input type="checkbox"/>
(please note we reserve the right to ask you to register with a GP closer to your home if we subsequently identify your home address as being outwith the Practice Boundary)	DON'T KNOW	<input type="checkbox"/>

So that you don't miss out on important information:	
The Practice uses a text messaging service to contact patients, e.g. for appointment reminders, flu vaccination, online services, general/health messages etc. Please complete the section below if you are happy to be contacted by text message.	
YES, I agree to being contacted by text message and will keep my registered contact details up to date with the Practice.	
Signed: _____	Print: _____ Date: _____

To be completed by Nurse:	
Weight.....	Height
Last tetanus vaccine	Last polio vaccine
Risk factors	

Please also complete NHS Application to Register permanently with a General Medical Practice form ref: GMSGPR001 which is also available at reception.

Glencairn Medical Practice
Modyrvale Medical Centre
Toll Street, Motherwell, ML1 2PJ
Tel: 01698 265566 Fax: 01698 253816

Dr. A. Porte • Dr. S. Tomlinson • Dr. D. Rimmer • Dr. F. Carr • Dr. D. Eckersall