# Aboyne Medical Practice Registration Form

## PERSONAL DETAILS

DO YOU REQUIRE ASSISTANCE / INTERPRETER TO HELP YOU COMPLETE THIS FORM?
If "yes" please make enquiries at reception.

| | | | |
|---|---|---|---|
| Surname | | Date of Birth | |
| Forename | | Marital Status | |
| Maiden Name | | Place of Birth | |
| | | Occupation | |

| | |
|---|---|
| Address | |
| If your address maybe difficult to find (even with sat nav), please give brief details. | |
| Tel: | Home: Mobile: Work: |

| | |
|---|---|
| Next of Kin & Tel no. | |

**It is the policy of Aboyne Medical Practice not to identify ourselves to a third party when contacting a patient by telephone. If you would like to give the practice consent to discuss personal/medical details with a nominated person, please enter their details here.**

Name of nominated person - Tel No:

| | | | | |
|---|---|---|---|---|
| Consent for ACP/KIS Upload (please see information sheet) | Yes | | No | |
| Have you served in the Armed Forces? | Yes | No | Service No: | |

**Please indicate if you have a Power of Attorney in place** Yes/No

**If so please hand in the original/certified true copy and we will photocopy this document and place in your medical records**

## MEDICAL HISTORY

Have you ever been in hospital for anything at all (i.e investigations/Operation)
If "Yes" please state when and what for.

Have you had any illnesses or problems you have needed to see your Doctor regularly for?
If "Yes" please give details, including dates where possible.

Do you suffer from any of the following conditions?

| | | | | | |
|---|---|---|---|---|---|
| ASTHMA | | DIABETES | | EPILEPSY | |
| HIGH BLOOD PRESSURE | | CANCER | | BRONCHITIS/PNEUMONIA | |

ALLERGIES – Are you allergic to any medicine or any other substances – eg, Pollen, nuts, other foods
If "Yes" please give details

MEDICINES – Please list any medicines, tablets or contraceptive pills you use regularly

| | |
|---|---|
| | |
| | |

FAMILY HISTORY - Does anyone in your family suffer from (presently or in the past) any of the following? Please tick and state how old they were at the time.

| | Mother | Father | Aunt | Uncle | Grandmother | Grandfather | Brother | Sister |
|---|---|---|---|---|---|---|---|---|
| **Heart Attack** | | | | | | | | |
| **Diabetes** | | | | | | | | |
| **Stroke** | | | | | | | | |
| **Asthma** | | | | | | | | |
| **High Blood Pressure** | | | | | | | | |
| **Cancer** | | | | | | | | |

VACCINATIONS – What date, approximately, did you have the following? Please list any you have had.

| Tetanus - | Polio - | Flu Vaccination - |
|---|---|---|
| | | |

## LIFESTYLE

| Do you look after someone? | Yes/No | Does someone look after you? | Yes/No |
|---|---|---|---|

Name of person who looks after you?.......................................................................................................

| Do you smoke? | Yes | If "Yes" how many? | | No | |
|---|---|---|---|---|---|

Please state type (cigarettes, cigars, tobacco)..........................................................................................

| Have you ever smoked? | Yes | No | If "Yes" when did you stop?.............................................................. |
|---|---|---|---|
| Do you drink alcohol? | Yes | No | If "Yes" how many units per week?................................................... |

1 unit = 1 glass wine, 1 measure spirit, half pint beer/lager

| What is your height? | | Is your diet balanced and healthy? | Yes |
|---|---|---|---|
| What is your weight? | | | No |

| How often do you exercise for 20 minutes or more at a time? (including brisk walking) Please state type of exercise. | |
|---|---|
| | |

## ETHNIC GROUP

You are not obliged to complete this section. Please tick as appropriate.

| I do not wish to give this information | |
|---|---|

| White | Chinese | Indian | Bangladeshi | Pakistan | Black African | Black Caribbean | Arabic | Other (please state) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

**Patient records are held on computer as well as paper. GP's are responsible for the confidentiality of these records. On occasions we share information from the patient records with the Health Authority, Primary Care Trust, Hospitals and other NHS specialists in the interest of patient care.**

**I agree to my medical records being held under the above terms and I certify that the information I have provided is correct to the best of my current knowledge.**

Name:....................................................Signature:...........................................Date:.........................

## CHILDHOOD VACCINATIONS

<u>This section should be completed if the form refers to a child.</u>

Developmental Assessments: (Please enter dates)

| 8 Wks: ........ /....... /....... | 8 Mths: ........ /....... /....... | 2 Yrs: ........ /....... /....... | 4Yrs : ........ /....... /....... |
|---|---|---|---|

Vaccination/Immunisations: (Please enter dates)

| | | | |
|---|---|---|---|
| 1st Diptheria/Tetanus/Pertussis (DTP); Polio, Hib | ........ /....... /....... | | |
| 2nd Diptheria/Tetanus/Pertussis (DTP); Polio, Hib | ........ /....... /....... | | |
| 2nd Diptheria/Tetanus/Pertussis (DTP); Polio, Hib | ........ /....... /....... | | |
| Pneumococcal | ........ /....... /....... | ........ /....... /....... | ........ /....... /....... |
| Meningitis C | ........ /....... /....... | ........ /....... /....... | ........ /....... /....... |
| MMR Measles/Mumps/Rubella | ........ /....... /....... | | |
| Pre-School Booster: Diptheria/Tetanus/Pertussis (DTP); Polio | ........ /....... /....... | | |
| Pre-School Booster: Measles/Mumps/Rubella (2nd MMR) | ........ /....... /....... | | |

| BCG | ........ /....... /....... | Measles | ........ /....... /....... | Rubella | ........ /....... /....... |
|---|---|---|---|---|---|

| OTHER IMMUNISATIONS – Please list below any other immunisations your child has had. | |
|---|---|
| | |
| | |
| | |

| Please state which GP Surgery/Clinic immunisations were given |
|---|
| |
| |

| Do you have any supporting paperwork to confirm your child's immunisation history?<br>**If "Yes" please supply with this completed form to enable copies to be taken.** | YES | No |
|---|---|---|

**Patient records are held on computer as well as paper. GP's are responsible for the confidentiality of these records. On occasions we share information from the patient records with the Health Authority, Primary Care Trust, Hospital and other NHS Specialists in the interest of patient care.**

**I agree to my son/daughters medical records being held under the above terms and I certify that the information I have provided is correct to the best of my current knowledge**

Patient's Representative Signature................................................ Relationship to Patient............................

Date..............................................