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:.....

Key Information Summary/ Anticipatory Care Plan

What is a Key Information Summary/Anticipatory Care Plan and why might I need one?

At present if you require Emergency or Unscheduled Medical or Nursing Care Out of Hours then the information available to the emergency services and Out of Hours Medical Services on your Emergency Care Summary is limited to your current Repeat Medication and possible Allergies.

A Key Information Summary/Anticipatory Key Summary allows more detailed and up to date information to be available. It may include additional information such as access or directions to your home if finding you during the day or at night could be difficult, Next of Kin or other more appropriate contacts, Medical Diagnoses and Current Treatments, your wishes about preferred Place of Care and Resuscitation Status, any Communication difficulties you may have or specialist wishes to name a few. It can be added to and modified by your GP or Community Nursing Team and this is instantly available and can also be removed at anytime.

Consent from the Patient is required before “uploading” of any information is possible and in our experience this is often where delays occur. These delays could therefore potentially affect your care and so in order to prevent this happening we feel that obtaining your consent “ahead of time” and storing it would be better.

Aboyne Medical Practice
Aboyne
AB34 5HQ

Text Messaging Service

Consent Form

Declaration

I consent to the Practice contacting me by text message to allow the Practice to send appointment reminders, cancel appointments, information on flu clinics, health promotion information and changes in service notifications.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling is still my responsibility.

The surgery does not offer a reply facility to enable patient to respond to texts directly.

Although text messages are generated using a secure facility, I understand that they are transmitted over a public network onto a personal telephone. As such they may not be secure, and therefore the Practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the Practice if my mobile number changes or if this is no longer in my possession.

If you would like to register for the service please complete this slip and hand into Reception

Patient name _____Date of Birth _____

Address _____

Mobile Number _____

Email address _____
(Please print clearly)

Date _____

The Practice does not share mobile phone contact details with any external organisation.
(As per Practice Privacy statement)

Please note that you can opt out from using the above service at anytime by contacting us on 0345 337 9955

WOMEN ONLY SECTION (16-60 YEARS)

IT IS VERY IMPORTANT THAT YOU COMPLETE THIS SECTION SO THAT WE HAVE AN ACCURATE SMEAR RECORD FOR YOU IMMEDIATLY.

- Have you been pregnant? YES/NO – If "No" please move to the next section.
- How many times have you been pregnant? .....
- How many deliveries have you had? .....
- Type of delivery? (e.g. normal, caesarean).....
- Any problems? E.g. raised blood pressure).....

IF YOU ARE OVER THE AGE OF 25 YEARS PLEASE COMPLETE THIS SECTION

- Date of last cervical smear test: .....
- Where was the test taken? Please tick below.

GP		HOSPITAL		ABROAD	
Family Planning Clinic		PRIVATE		OTHER	

What was the result? Please tick below

NORMAL routine recall - 3 years		ABNORMAL	
NORMAL early recall - 1 year		BORDERLINE CHANGES recall - 6 months	
NORMAL early recall - 6 months		INADEQUATE recall - 3 months	

- If abnormal are you currently having treatment? Yes ☐ No ☐
- Have you had an abnormal smear in the last 10 years? Yes ☐ No ☐

- I DO NOT REQUIRE CERVICAL SCREENING SERVICES? ☐
  (ie. Due to hysterectomy, never sexually active etc)
- If you have had a total hysterectomy please give the date:.....
- Reason:.....

Are you currently using contraception?	Yes		No	
If "Yes" what type of contraception?	If you have an Nexplanon, IUS or IUCD fitted please give date when fitted Date			
If you are aged between 50 – 60 when did you last have a mammogram?	Date:			

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