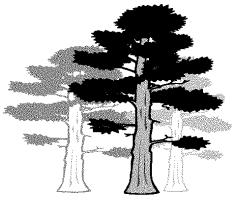

DRs REID, MCDERMOTT, STIMPSON, MILLER, ROBERTSON, ROLFE & PARRY
COLINTON SURGERY 296B COLINTON ROAD EDINBURGH EH13 0LB TEL. 0131 441 4555

NEW PATIENT REGISTRATION SHEET (ADULT) PERSONAL AND MEDICAL DETAILS

SURNAME …… FORENAME …… DOB …….

ADDRESS ……. …….

POSTCODE ……. ..MARITAL STATUS …….. ….. TITLE …..... NO. OF CHILDREN ……

]HOME TEL NO. ……..... MOBILE TEL NO. …….

DATE MOVED TO NEW ADDRESS.....

SMOKING – ARE YOU **A SMOKER/EX-SMOKER/NEVER SMOKED** – please circle
If you are a smoker and would like help to stop please ask at reception

ALCOHOL – HOW MANY UNITS DO YOU DRINK PER WEEK …… (1 unit = ½ pint beer)

EXERCISE – DO YOU TAKE REGULAR EXERCISE – HEAVY/MODERATE/LIGHT/NONE

WHAT IS YOUR HEIGHT ……. AND WEIGHT …….

PLEASE LIST YOUR CURRENT ILLNESSES AND/OR HOSPITAL ATTENDANCES

……

……

……

PLEASE LIST YOUR PAST MEDICAL HISTORY INCLUDING HOSPITAL ADMISSIONS, OPERATIONS AND SPECIAL INVESTIGATIONS

……

……

……

DO YOU HAVE ANY ALLERGIES ……..

FEMALES ONLY

DATE AND TIME OF YOUR LAST CERVICAL SMEAR ……

HAVE ANY SMEARS BEEN ABNORMAL …….

ARE YOU IMMUNE TO RUBELLA (GERMAN MEASLES) …….

DO YOU HAVE A COIL (IUCD) FITTED – YES/NO …… PTO >

CURRENT MEDICATIONS

PLEASE ENTER THE DRUG NAME, STRENGTH AND FREQUENCY OF MEDICATION					
DRUG NAME	STRENGTH	8AM	NOON	6 PM	10 pm
Eg. Paracetamol	150mg	2	0	2	0

If you require more space please use separate sheet

FAMILY HISTORY – Please supply details of illness of close relatives eg. Heart disease, stroke, diabetes

	Alive/Age	Well	Significant Illness	Age at death	Cause of death
Mother					
Father					
Brother					
Brother					
Sister					
Sister					

PLEASE GO TO NEXT PAGE TO COMPLETE NOK DETAILS

NAME …… DOB ……

CONSENT AND NOK DETAILS

WOULD YOU BE CONTENT FOR COLINTON SURGERY TO CONTACT YOU BY TEXT? YES [9NdP.00] ☐ NO [9NdQ.00] ☐

AS PART OF YOUR MEDICAL CARE MAY WE SHARE INFORMATION WITH THE OUT OF HOURS SERVICE, HOSPITALS AND OTHER EMERGENCY SERVICES? ***YES/ NO***
(This is done via making your KIS (Key Information Summary) available. Consent can be withdrawn at any time by contacting the Surgery).

PREFERRED LOCAL PHARMACY .....
(all repeat prescriptions will be forwarded to this pharmacy – see website for details)

HAVE YOU EVER BEEN REGISTERED WITH THE PRACTICE BEFORE? ***YES/NO***

HAVE YOU EVER BEEN IN THE ARMED FORCES ***YES/NO***

IF YES PLEASE GIVE DETAILS ……

IS THERE ANYONE LIVING AT THE SAME ADDRESS REGISTERED WITH THIS PRACTICE –

PLEASE GIVE THEIR NAME AND RELATION: …….

NEXT OF KIN/FRIEND/CARER DETAILS ……..

NAME …… CONTACT NUMBER ……

POWER OF ATTORNEY OR GUARDIANSHIP

NAME …… CONTACT NUMBER ……

.

PLEASE NOTE THAT WE CANNOT ARRANGE AN APPOINTMENT FOR YOU UNTIL YOUR REGISTRATION FORMS HAVE BEEN RETURNED TO US

DATE OF COMPLETION ……..

ALL INFORMATION GIVEN WILL BE STRICTLY CONFIDENTIAL