



Welcome to Whinpark Medical Practice.

It is important that we establish your right to NHS treatment before you join the Practice and in order to do this we require to see the following documents.

1. Photographic ID (passport, ID card, working visa or driving licence)
2. Proof of address in your name (mortgage/rental agreement, utility bill, bank statement, current employment details)

If you were born outwith the UK you must provide a passport and a visa if appropriate. If you are the spouse of someone who has a working visa you will be asked to provide a marriage certificate or proof of co-habitation before your registration is accepted

Children under 16 are covered by a parent's application.

If you are unable to provide the required documentation you will not be able to register with this practice under the National Health Service and you will be required to pay for any consultation, treatment or prescription you receive.

It may be some time until we get your previous medical records. It is, however, very useful for us to know a bit about your medical history while we are waiting for your records to arrive. To help us with this we would be grateful if you would complete **all sections** and return the attached questionnaire. Registration cannot be processed until this is completed.

We can offer you a registration appointment with one of our nurses to check your blood pressure, record your height and weight and other important information about your past and present health. Please indicate below if you would like to have a registration appointment. Children between the ages of 5 and 16 registering with the practice **MUST** have a registration appointment.

Yes, I would like to make a registration appointment. *(Please note this appointment is for registration purposes only and not for any acute illness or to get any medication)* Please bring a urine sample with you. Sample bottles are available from reception.

Practice Use Only:

Identification: Passport/Driving Licence/Medical Card

Initials

Proof of Residency:

Initials

Date of NRM

.../.../....

BP:	.../.../...	Urinalysis	
Contraception advice	YES/NO	Smoking cessation advice	YES/NO
Alcohol Brief Intervention	YES/NO	Lifestyle advice	YES/NO
Breast/Bowel Screening advice	YES/NO	Notes:	

NEW REGISTRATION QUESTIONNAIRE

PLEASE COMPLETE ALL SECTIONS.

Name (including title):	Date of Birth:
Address: Post Code:	Tel. No: Home Work Mobile
Marital Status:	Occupation:
Height:	Weight:
Have you previously been registered with this practice? YES/NO (delete as appropriate)	Name & Address of Next of Kin:
Names & dates of birth of household members registered with this practice:	Emergency Contact Name and Number:
Are you a Carer? YES/NO (delete as appropriate) If you are you a Carer are you aged 16 or under? YES/NO (delete as appropriate)	If you are a Carer please give details of the person you care for (including your relationship to them, whether they live with you & whether they are registered with this practice)

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PERSONAL MEDICAL HISTORY

Please list any major illnesses and any admissions to hospital:

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Please list any known allergies:

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If you are on regular medication (including contraception) please list the name and the dose of the medication:

.....Dose.....
.....Dose.....
.....Dose.....
.....Dose.....

If you are aged between 50 and 74 do you participate in the Scottish Bowel Screening Programme YES/NO (delete as appropriate)

For women only:

What type of contraception do you use?

What is the date of your last smear?.....Result

How many pregnancies have you had?.....

What are your children's names and dates of birth?.....

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Have you had breast screening? YES/NO (delete as appropriate)

FAMILY HISTORY

Please list any illnesses that close relatives (parent, brother or sister) have been diagnosed with eg Diabetes, epilepsy, heart disease, stroke, high cholesterol, high blood pressure, cancer or any inherited problems

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SOCIAL HISTORY

DO YOU SMOKE? Yes, current smoker How many per day

Ex Smoker Date stopped/...../.....

Never smoked

WE STRONGLY ADVISE ALL PATIENTS NOT TO SMOKE. ATTENDING SUPPORT CAN INCREASE YOUR CHANCES OF QUITTING. SESSIONS CAN BE TAILORED TO YOUR NEEDS. TELEPHONE **0800 84 84 84** FOR MORE INFORMATION OR ASK AT RECEPTION.

DO YOU DRINK ALCOHOL? YES/NO (delete as appropriate)

If so, how much do you think your **average weekly alcohol intake** is?

(1 Unit = ½ pint of beer, a small glass of wine or a single measure of spirit – the safe limit for men and women is 14 units per week maximum)

None 1-7 8-14 15-21 More than 21

IF YOU (OR SOMEONE CLOSE TO YOU) ARE CONCERNED ABOUT YOUR ALCOHOL INTAKE THEN PLEASE MAKE AN APPOINTMENT WITH A GP TO DISCUSS HOW WE CAN HELP YOU.

DO YOU OR HAVE YOU EVER TAKEN RECREATIONAL DRUGS? YES/NO (delete as appropriate)

DO YOU TAKE REGULAR EXERCISE?

YES daily 2-3 times per week Occasionally Never UNABLE due to health

DO YOU CONSIDER YOUR DIET TO BE HEALTHY? YES/NO (delete as appropriate)

DO YOU NEED HELP WITH ANY OF THE FOLLOWING?

Housing YES/NO (delete as appropriate)

Financial Debt YES/NO (delete as appropriate)

Benefits Advice YES/NO (delete as appropriate)

ARE YOU WORRIED ABOUT OR REQUIRE HELP WITH ANY OF THE FOLLOWING?

Isolation YES/NO (delete as appropriate)

Loneliness YES/NO (delete as appropriate)

Vulnerability YES/NO (delete as appropriate)

Domestic Violence YES/NO (delete as appropriate)

Female Genital Mutilation YES/NO (delete as appropriate)

WHICH ETHNIC GROUP DO YOU BELONG TO?

Chose ONE section from A to E, and then tick the appropriate box within that section to indicate your ethnic group

A. WHITE

- Scottish Welsh British Polish
- English Northern Irish Irish Gypsy/Traveller
- Other White ethnic group, please specify

B. MIXED OR MULTIPLE ETHNIC GROUPS

- Please specify

C. ASIAN, ASIAN SCOTTISH OR ASIAN BRITISH

- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British
- Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- Any other Asian background, please specify

D. AFRICAN, CARIBBEAN OR BLACK

- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Any other Black background, please specify

E. OTHER ETHNIC GROUP

- Arab
- Other, please specify

F. NOT STATED

-

DO YOU REQUIRE AN INTERPRETER?

(please indicate which language you speak)

YES/NO (delete as appropriate)

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DO YOU NEED SIGN LANGUAGE SUPPORT OR TOUCH TALK?

YES/NO (delete as appropriate)

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