Adam Avenue Practice

NEW PATIENT REGISTRATION FORM

<u>IMPORTANT</u> – Please contact surgery within 7-10 days of handing in this form to arrange a new patient registration appointment.
If you are on any medication, please ensure you have enough to cover you when changing practice.

Your case notes may take several weeks or months to be transferred to our practice from your previous GP. Could you please fill in this form with your medical details to enable us to treat you in the meantime.

We sometimes share your personal health information with other organisations involved with your health care. We only share relevant information. For example, when your GP refers you to a specialist at the hospital we send relevant details about you in the referral letter and receive information back from them about you. We sometimes share information including your name, address and date of birth so that you can be invited for health screening.

The law sets out how we can use your personal health information. The Data Protection Act gives you rights about how your personal information is used, including a right to see the information we hold about you.

All NHS staff have a legal duty to keep information about you confidential and they follow a staff Code of Practice on Protecting Patient Confidentiality.

NAME……DOB……

ADDRESS……

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TEL No…… EMPLOYED YES NO

ETHNIC ORIGIN	White – UK	White – Other
Asian – Bangladeshi	Asian – Chinese	Asian – Indian
Asian – Other	Asian – Pakistani	Black – African
Black – Caribbean	Black – Other	Mixed Race
Gypsy Traveller	Occupational Traveller	Other Traveller

Other (Please Specify)……

MARRIED/SINGLE/WIDOWED No OF DEPENDANTS……

ANY KNOWN ALLERGIES……

DO YOU SMOKE YES NO IF YES HOW MANY DAILY……

ARE YOU AN EX – SMOKER YES NO

ALCOHOL INTAKE – HOW MANY UNITS PER WEEK……

DO YOU EXERCISE YES NO HOW OFTEN……

DO YOU LOOK AFTER SOMEONE YES NO

DOES SOMEONE LOOK AFTER YOU YES NO

ARE YOU HOUSE BOUND YES NO

Please note that **<u>ALL</u>** prescriptions will go to your selected pharmacy unless otherwise specified.

DATE OF LAST SMEAR TEST……RESULT……

DATE OF LAST MAMMOGRAM……RESULT……
PLEASE LIST ALL VACINATIONS/IMMUNISATIONS AND DATES (IF THIS FORM IS FOR A CHILD UNDER THE AGE OF SIX, PLEASE CONFIRM WHETHER THEY ARE UP TO DATE WITH THEIR CHILDHOOD IMUNISATIONS).

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HAVE YOU OR ANY FAMILY MEMBERS BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS

CONDITION	**YOU**		**FAMILY MEMBER - STATE RELATIONSHIP TO YOU**
HEART CONDITION	YES	NO	……
DIABETES MELLITUS	YES	NO	……
ASTHMA OR COPD	YES	NO	……
EPILEPSY	YES	NO	……
CANCER	YES	NO	……
THYROID PROBLEMS	YES	NO	……

OTHER ……

PLEASE LIST ANY MEDICATION YOU ARE TAKING

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Please be advised the practice strictly follows national guidance on the use of pain relieving medication. If your current medication does not fall within this guidance it will be reviewed. If you are prescribed multiple pain relieving medications, these will be rationalised as appropriate

Prescription Requests

If you require a prescription in the future, this can be collected at the surgery or sent to a pharmacy in the area. Please tick below the pharmacy you would like your prescriptions to go to;

McNish Pharmacy, Caldercruix	( )	Boots Pharmacy, Graham St (Big Boots)	( )
Sinclair Pharmacy, Plains	( )	Boots Pharmacy, Graham St (Small Boots)	( )
Health Pharmacy, Clarkston	( )	Boots Pharmacy, Bank St	( )
Craigneuk and Petersburn Pharmacy	( )	Boots Pharmacy, South Bridge St	( )
Calderbank Pharmacy	( )	Mint Pharmacy, Carnbroe	( )
Lloyd Pharmacy, Airdre	( )	Monklands Pharmacy,	( )
Lloyds Pharmacy, Chapelhall	( )	Dickson Pharmacy, Glenmavis	( )

Please note that **ALL** prescriptions will go to your selected pharmacy unless otherwise specified.