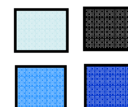

LIBERTON MEDICAL GROUP
NEW REG ADULT

Today's date

Have you been registered at this Practice before:
YES NO

Title

First name

Surname

Address

Postcode

Next of Kin Relationship
Contact No

Date of birth:

Home Tel No:
Mobile No.

Have you been a member of HM Forces
YES NO

Nationality
Interpreter Required YES NO
Language Spoken :

How do you wish to be addressed? Name:

Do you have an HGV/Bus/Coach or Taxi Licence? YES ☐ NO ☐

Please list any operations or serious illnesses:

Do you have or have you ever had:

Asthma	☐	Date Diagnosed
Diabetes	☐	Date Diagnosed
Chronic Bronchitis	☐	Date Diagnosed
A Stroke of Transient Attack (TIA)	☐	Date Diagnosed
Under active thyroid	☐	Date Diagnosed
Heart Attack or Angina	☐	Date Diagnosed
Epilepsy	☐	Date Diagnosed
High Blood Pressure	☐	Date Diagnosed

Weight …………………………………………… Height ………………………………………….

Has anyone in your family had any of the following:

Heart Attack ☐ Age ( ) Stroke ☐ Age ( ) High Blood Pressure ☐
Asthma ☐

Cancer under the age of 50 if so please give details ______________________________________

In your family are there in genetic disorders that you are aware of Yes ( ) No ( )
What Condition If known ____

Are you taking any medication?

Name	Dose	How Often

Do you have any allergies?

Diet: Good ☐ Poor ☐ Exercise: Good ☐ Poor ☐

Occupation: Are you a carer: YES/NO

Name of Person you care for If a patient here Name __________ DOB _________________

Do you drink? Yes / never How many units of alcohol per week?
(1 unit = 1 glass of wine, 1 pub shot of spirits or 1/2 pint beer)

Do you smoke? Yes/No/Ex smoker
If Yes: How many do you smoke?
If Ex: How many did you smoke?

Immunisations:

When was your last tetanus? Date: Over 10 years ago ☐ Don't know ☐

When was your last polio? Date: Over 10 years ago ☐ Don't know ☐

Have you ever had a Pneumococcal vaccination? Date: YES ☐ NO ☐

Do you give consent to the GPs sharing significant medical information with Out of Hours Services?

Please sign here:

Signature: ……………………………. ………………. Date: …………..

Ladies:

When was your last cervical smear? Date: Over 5 years ago ☐ Don’t know ☐

Was the smear taken in the UK. Yes ☐ No ☐

Was it a normal result? Yes ☐ No ☐

Have you ever had a mammogram? (breast x-ray) Yes ☐ No ☐

Current contraception used?

Number of pregnancies ☐

To be completed by the Doctor/Practice Nurse

Blood Pressure /

Urinalysis

Action

Data in Vision ☐

Referred to GP YES ☐ NO ☐

Date completed:

Future developments within the NHS may make it possible for us to contact you via text messaging and email for services such as appointment reminders and annual disease management recall. In preparation for this change we would like to obtain your consent to contact you in this way and record your current contact details. It is also important that the information we hold is kept up to date. Please keep us informed of any changes to your contact details. Please tick box to indicate consent and complete your details in the boxes below. **PLEASE TICK EACH INDIVIDUAL BOX TO INDICATE YOUR CONSENT AND RETURN THE COMPLETED FORM TO RECEPTION STAFF.**

		Consent to contact by:
Mobile Number:		☐
Landline:		☐
Personal email:		☐

I am a current smoker ☐ **How many do you smoke?** ☐ **I am an ex smoker** ☐ **How many did you smoke?** ☐ **I have never smoked** ☐	If you are a smoker and want to quit please call the local Stop Smoking Support Service on 0131 672 9532 or call SMOKEFREE on 0800 84 84 84 or visit http://smokefree.nhs.uk or your local pharmacy. Trained NHS advisors can provide friendly help and encouragement.