THISTLE MEDICAL PRACTICE

Welcome to our practice, in order to process your application we must ask you to complete the following questions. The reception staff will also ask you to attend the treatment room for a small medical. Please take a sample of urine with you when you visit the nurse.

Two forms of identification are required prior to registration – it would be helpful for one to have a photograph in place.

FULL NAME ……………………………………………….. ……………………

ADDRESS ………………………………………………………………....................

POSTCODE ……………………… **DATE OF BIRTH** ………………….

TELEPHONE: HOME .... **MOBILE** ……………………………

WORK ………………………………… **OCCUPATION** …………………….

PREVIOUS GP'S NAME …………………………………………………………

ADDRESS ………………………………………………………………………….

Are there any other members of your family patients of this practice? Yes/No

ABOUT YOU	**YES**	**NO**
SMOKING: Do you smoke? If Yes, how many per day? Are you an ex smoker? How long since you stopped? ……… Months …….. Years ALCOHOL: Do you drink alcohol? If Yes, how much? EXERCISE: Do you take any exercise? If Yes, What type of exercise: How often?		

PAST MEDICAL HISTORY:
Please summarise any serious illness, accidents, operations or disabilities:

DATE	PROBLEM

MEDICATION:
Please list any medication you are on at present:

Do you take over the counter aspirin? Yes □ No □

ALLERGIES: Do you suffer from any allergies? Yes □ No □

If yes what type? ………………………………….

FEMALES ONLY:
When was your last cervical smear test? ……………… Result ………………

CARERS: Do you care for anyone who cannot manage at home without help?

Is the person? Relative □ Friend □ Neighbour □ **Do you care** full time □ part time □

FAMILY HISTORY: Is there any family history of any of the following?

Coronary Heart Disease i.e. Heart Attack Yes □ No □	Which family member? Over 60 years old/Under 60 years old
Diabetes Yes □ No □	Which family member? Over 60 years old/Under 60 years old
Asthma Yes □ No □	Which family member? Over 60 years old/Under 60 years old
Cancer Yes □ No □ What type?	Which family member? Over 60 years old/Under 60 years old

NEXT OF KIN:

NAME: ………………………………………………………….

ADDRESS: ………………………………………………………….

CONTACT NO: …………………………………………………….

Patient Signature…………………………………….. **Date**…………………

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care. Please ask a member of staff if you need more explanation.

We should be grateful if you could complete one for each family member within/ joining the Practice.

Do you need an interpreter or sign language support? Yes ☐ No ☐

If you need an interpreter, which language do you speak?

Please state …………………………………………………………………..

What is your Ethnic group?

Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background.

A White

☐ Scottish
☐ English
☐ Welsh
☐ Northern Irish
☐ British
☐ Irish
☐ Gypsy/ Traveller
☐ Polish
☐ Any other white ethnic group, please specify ……………………………………

B Mixed or Multiple ethnic groups

☐ Any mixed or multiple ethnic group

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
☐ Other, please specify ……………………………………………………………

D African, Carribean or Black

☐ African, African Scottish or African British
☐ Carribean, Carribean Scottish or Carribean British
☐ Black, Black Scottish or Black British
☐ Other, please specify ……………………………………………………………..

E Other ethnic group

☐ Arab
☐ Other, please specify ………………………………………………………………

If you do not wish to give this information, please tick here ☐

Note

We may at times have to share your medical information with other Health Care Professions, this information will be treated in strict confidence and is used to collate statistical data in specific disease areas, e.g. Asthma, Diabetes, Hypertension, etc.

Please sign if you find this acceptable

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For Practice Use Only

ID Presented and copied: Yes ☐ No ☐

For nurse use only

Height: Weight:

BP: Urinalysis:

Smoking Cessation Advice Offered: Yes ☐ No ☐

Tetanus Booster given:

Other relevant information:

Medication discussed with Pt: Yes ☐ No ☐

Date of medical: