DR. BARBARA STEWART
DR. RICHARD COCKBURN
DR ALASDAIR FORD
DR. HOLLY CAKEBREAD
DR. SUSAN PEDDIE

165 COLINTON MAINS DRIVE
EDINBURGH EH13 9AF

TEL 0131 441 3119

# ADULT New Registration Form

**We are pleased that you have applied to register with this practice. By providing the following information you will help us to understand your medical requirements as well as assisting us with the registration process. The information you give will be treated in the STRICTEST CONFIDENCE. Please complete this form as fully as possible and return it to reception. You should have been offered a *Practice Brochure* describing the services we offer. Should you wish a brief medical examination please bring a fresh urine sample to the first appointment you make to see us. Please note that you are NOT registered with this practice until a doctor has agreed to take you onto the practice list.**

DATE ....................

**NAME**

TITLE (Mr., Mrs., MS, etc.) FIRST NAME(S) SURNAME/FAMILY NAME SEX MALE/FEMALE

**DATE OF BIRTH**
DAY / MONTH / YEAR

**NHS Number**
( if known)

**ADDRESS**

**Post code** **Tel Number**
**Mobile No**

**OCCUPATION**
PRESENT

PREVIOUS

**Who else lives at this address with you?**

**Your Previous Address:**

**Name & Address of last GP**

Please tick here if you **consent** to the Practice sending text message appointment reminders and general information texts to you.
I consent ☐

I do not consent ☐

**Next of Kin : Name**

Relationship :

Mobile/Tel.No:

Address:

**Carers** (A carer is defined as someone who provides regular help with essential daily activities eg washing, dressing, toileting, help with feeding, to another individual without being employed to do so.)

Are **you** a carer? No Yes Who do you care for?

Are you cared for? No Yes By whom?

**PERSONAL HEALTH**

Please list any serious illnesses, hospital admissions or operations you have had :

| Year | Hospital | Nature of Illness/Operation |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please tick here if you have no significant history or problems** ☐

**Do you have or have you had any of the following conditions? (Please circle)**

| | |
|---|---|
| Asthma | Diabetes |
| Chronic Bronchitis/Emphysema | Thyroid Disease |
| High Blood Pressure | Dementia |
| Angina/Coronary Artery Disease | Learning Difficulty |
| Stroke/TIA's | Schizophrenia/Bipolar disorder |
| Chronic Kidney Disease | Cancer |

**PLEASE TICK HERE IF YOU ARE NOT TAKING ANY MEDICATION REGULARLY** ☐

# MEDICATION

# PHARMACY ☐

**I take the following medication regularly** (please bring labelled containers) :-

**I am allergic to:**

**I use/have used the following recreational drugs:**

**FAMILY MEDICAL HISTORY** Please enter details about **YOUR** family

| | IF ALIVE | | IF DEAD | |
|---|---|---|---|---|
| | AGE(s) | STATE OF HEALTH | AGE AT DEATH | CAUSE OF DEATH |
| Wife/Husband | | | | |
| Mother | | | | |
| Father | | | | |
| Brother(s) | | | | |
| Sister (s) | | | | |
| Child(ren) | | | | |

**Your Smoking History:**

I have never smoked ☐ I started smoking in (Year) ☐

I stopped smoking in (Year) ☐

I still smoke **or** I used to smoke :- <1 cig/day ☐ 1-9 cigs/day ☐
10-19 cigs/day ☐ 20-39 cigs/day ☐ 40+ cigs/day ☐ I smoke cigars/pipe ☐

**On an average DAY I drink the following number of units of alcohol:-**
A unit is roughly equivalent to a small glass of wine, a half pint of beer or a single measure of spirits.

Zero units ☐ 1 to 2 units ☐ 3 units ☐ 4 units ☐ >4 units ☐

I have had problems in the past drinking excessive amounts of alcohol ☐

**In an average WEEK I eat fruit and vegetables :-**

Never ☐ 3 times ☐ Every day ☐

**In an average WEEK I exercise to the point of getting out of breath :-**
Once per week ☐ 2 times per week ☐ 3 times per week ☐ Every Day ☐

| I am not able to take any regular exercise | ☐ | I am unable to leave my house without help | ☐ |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **My Weight is** | **…….kgs** | **or** | **…….stones and ..…….pounds** |
| **My Height is** | **………cm** | **or** | **………feet and ……… inches** |

**For women only**

**ARE YOU CURRENTLY PREGNANT? YES / NO If yes how many weeks** ☐

**HOW MANY PREGNANCIES** ☐ **, MISCARRIAGES** ☐**, TERMINATIONS** ☐ **HAVE YOU HAD ?**

**ARE YOU IMMUNE TO RUBELLA (GERMAN MEASLES)? YES / NO / DON'T KNOW**

**METHOD OF CONTRACEPTION?** Please circle **PILL COIL CAP SHEATH STERILISATION**

**HAVE YOU HAD A HYSTERECTOMY? YES / NO WHEN ?**

**DATE OF LAST CERVICAL SMEAR?** month / year **NORMAL / ABNORMAL**

**ANY TESTS FOR BREAST CANCER? YES / NO WHEN ?**

**DO YOU EXAMINE YOUR BREASTS REGULARLY? YES / NO**

**Ethnic Origin**

Please indicate your ethnic origin by ticking the box which most closely reflects your background.

White

Scottish ☐ .9S13 | British ☐ .9S10 | Irish ☐ .9S11 | Other White background ☐ .9S12

Asian, Asian Scottish or Asian British

Indian ☐ .9S6 | Pakistani ☐ .9S7 | Bangladeshi ☐ .9S8 | Other Asian background ☐ .9SH

Black, Black Scottish or Black British

Caribbean ☐ .9S2 | African ☐ .9S3 | Other Black background ☐ .9SG

Chinese ☐ .9S9..

Mixed

White & Black Caribbean ☐ .9SB5 | White & Black African ☐ .9SB6 | White & Asian ☐ .9SB2

Other Mixed background ☐ .9SB4

Any other background ☐ .9SJ

If you do not wish to state your ethnic background please tick this box ☐ .9SD

Main language spoken ……………………………………….

Will you require an interpreter when you consult the doctor or nurse? Yes ☐ No ☐

Practice use only :

BP ☐ Urinalysis (multistix) ☐