**WELCOME TO THE PRACTICE**

Drs M Johnston, Dr P Murray, Dr T Randall, Dr C Johnston, Dr N Harper, Dr L Fraser, Dr J Flinn, Dr C Gordon

**Patient Health Form**

|  |  |
| --- | --- |
| **Have you previously registered with this practice?**  | **YES / NO** |

|  |  |
| --- | --- |
| Surname |  |
| First name(s) |  |
| Date of Birth |  |
| Mobile / contact tel no. |  |
| Email address |  |
| Occupation |  |
| Are you registered Disabled? | YES / NO |
| Number of Children/DependantsAge(s) |  |
|  |  |
| Is there any “**family history**” of the following (family meaning parents, brothers, sisters). Those marked \* only answer if you are under the age of 60 |
| \*Stroke □ \*Angina/Heart Attack □ Diabetes □ Asthma □ High Blood Pressure □ |
|  |  |
| Ethnicity: White Scottish □ White British □ Indian □ Chinese □ European □ Other Asian □…………......... |
| What is your first Language? |  |
| Do you need an interpreter? |  |
|  |  |
| Do you have a carer?(if yes, please give details) |  |
| Are you a carer?(if yes, please give details) |  |

|  |  |
| --- | --- |
| Are you a veteran? |  |

Have you suffered any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| Epilepsy | YES / NO | Blindness / Glaucoma | YES / NO |
| High Blood Pressure | YES / NO | Diabetes | YES / NO |
| Heart Attack / Stroke | YES / NO | Asthma | YES / NO |
| Cancer | YES / NO | COPD | YES / NO |
| Depression | YES / NO | Hay Fever | YES / NO |
| Other Mental Health problem | YES / NO |  |  |

Please give details of any operations, serious illnesses or hospital admissions

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

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

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  Your Height: ………………………………… Your Weight: ……………………………...

|  |  |
| --- | --- |
| Do you smoke? | YES / NO |
|  If yes, how many per day? |  |
| Have you ever smoked? | YES / NO |
| Would you like advice to stop? | YES / NO |

|  |  |
| --- | --- |
| Do you drink Alcohol? |  |
| How many units of Alcohol per week do you drink? |  |

 Do you take regular exercise? : …………………………………………………………………………………………….......................... |

**WOMEN ONLY**:

|  |
| --- |
| Have you had a smear test YES / NO Date of last test………………… Result:……………….. |
| Do you have a coil (IUCD) fitted YES / NO  If yes, please give date? ……………………. Date of last check ……………… |
| Do you have a contraceptive implant YES / NO   If yes, please give date?.......................... |

**CURRENT MEDICATIONS**

WE LIKE YOU TO HAVE A PRINTED LIST (DATED WITHIN THE LAST 2 WEEKS) FROM YOUR LAST DOCTOR, PLEASE HAND THIS TO THE RECEPTIONIST WITH THIS FORM.

WE MAY NEED TO CONTACT YOUR PREVIOUS GP BEFORE WE CAN PRESCRIBE FOR YOU.

THIS IS FOR YOUR OWN SAFETY.

**N**ame **of medication Dose**

**------------------------------------------------------------------------------ ---------------------------------------------------------**

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**ALLERGIES**

Please give details of any allergies (foods, medications etc)

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**Next of Kin**

|  |  |
| --- | --- |
| **Name** |  |
| **Address****Postcode** |  |
| **Contact Number** |  |
| **Relationship to you** |  |
|  |
| **Do you hold a living will?**  | **YES / NO** |
| A **living will** is a written, legal document that spells out medical treatments you would and would not want to be used to keep you alive, as well as your preferences for other medical decisions, such as pain management or organ donation. |

**Patient Access: (ordering medication and booking appointments online).**

* **I would like to sign up for EMIS Patient Access YES / NO**
* **Please send me the registration details by email. YES / NO**

**I would like to sign up for text reminder services when they become available.**

**I confirm that all the above details are correct.**

**I accept that it is my responsibility to keep the surgery informed of all changes to any of my contact details.**

|  |  |
| --- | --- |
| **Signed:** |  |
| **Date** |  |

**THANK YOU.**

**PLEASE PICK UP A COPY OF OUR PRACTICE BOOKLET OR VISIT** [**WWW.COWDENBEATHMEDICALPRACTICE.CO.UK**](http://WWW.COWDENBEATHMEDICALPRACTICE.CO.UK)

**THIS PROVIDES YOU WITH USEFUL INFORMATION ABOUT THE PRACTICE**

**IF YOU HAVE A MEDICAL CARD PLEASE HAND IT TO RECEPTION WITH THIS FORM**

**COWDENBEATH MEDICAL PRACTICE**

|  |  |
| --- | --- |
| 173 Stenhouse Street Cowdenbeath Fife KY4 9DH Tel. No. 01383 518500 Fax No. 01383 518509  | Dr. Marion JohnstonDr. Natalie Harper Dr. Paul MurrayDr. Lucy FraserDr. Colin JohnstonDr. Tom RandallDr Jenny FlinnDr Carla Gordon |
| Practice Manager: Mrs Lisa Herd |  |

**CONSENT**

NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temporary Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applies)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE SECTION **1 OR 2** WHICH EVER SECTION APPLIES

 **SIGN SECTION 3**

**SECTION 1**

**I\*consent / \*DO NOT consent** to the release of \*FULL or \*PART of my medical records by Cowdenbeath Medical Practice to:

..............................................................................................................................................................................

If Part medical records, please specify dates from …………………to…………………………………..........

**SECTION 2**

\*I consent to my Registered GP/GP Practice releasing medical information to Cowdenbeath Medical Practice for the purposes of health care provision during my temporary registration with Cowdenbeath Medical Practice

Key Information Summary/Emergency Care Summary :

\*I consent to Cowdenbeath Medical Practice accessing my emergency care summary, hospital electronic records for the purpose of health care provision etc.

Registered GP Name/Practice: ………………………………………………………………………..............

Tel: ………………………………………………………..

I understand that all written communications regarding my health care will still be sent to me at my address registered with Cowdenbeath Medical Practice

**SECTION 3**

Signed Consent:……………………………………………………………………………..

Print Name: ………………………………………………… Date: ………………….