**PATIENT PRE-REGISTRATION FORM**

**WELCOME TO LOUGHVIEW MEDICAL CENTRE**

All new patients are requested to complete a patient questionnaire and a patient health questionnaire, as it will help us to understand your needs/requirements better prior to your full medical notes arriving from your previous doctor.

**All information held is strictly confidential**.

*About Yourself*

Surname …………………………………………………………………………………………………………………………

All other names ………………………………………………………………………………………………………………

Title …………………………............

Gender ……………………................................. Marital Status…………………………………………………..

Any previous surname (s) ………………………………………………………………………………………………..

DOB ………………………………………………….. DD MM YYYY

Are you registering on your own? YES / NO

Are you registering with your family or partner/spouse? YES / NO

**If yes please give names**…………………………………………………………………………………………………..

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Current address ……………………………………………………………………………………………………………….

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………………………………………………………………………….. Postcode …………………………………………….

Home phone no… ………………………………………. Mobile no ………………………………………………….

**Previous address**… ……………………………………………………………………………………………………………

Nationality. …………………………………………………………………………………………………………………………

E-mail address… ……………………………………………………………………………………………………………………

Place of birth.. …………………………………………………………………………………………………………………….

Previous GP (Name, address and contact telephone number)

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Please provide **HEALTH & CARE NUMBER**.…….………………….………………………………………….

Previous patient here YES / NO

Next of Kin (Name and contact details)……… ……………………………………………………………………..

……………………………………………………………………………………………….…………………………………………

**HEALTH AND MEDICATION**

Do you suffer from any of the following?

Heart Disease YES / NO

Asthma YES / NO

Diabetes YES / NO

High blood pressure YES / NO

Stroke YES / NO

Cancer YES / NO

Mental Health YES / NO

**If yes please give brief description:**

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Do any of your immediate family suffer from any of the above?

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Please list all medications on repeat, please also attach a copy of your prescription counterfoil from your current GP.

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Do you take any medications **NOT** issued on repeat? YES / NO

Name of medication (s) …………………………………………………………………………………………………….

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Have you had any **reactions** to or unwanted side effects from any medication?

YES / NO – If yes please give details:

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Do you have any **allergies**? YES / NO – If yes please give details:

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**FEMALE PATIENTS**

Have you had a recent **cervical smear?** YES / NO

Are you currently **pregnant?** YES / NO

If yes how many weeks?

Childhood Immunisations – are they up to date? YES / NO

If you are returning from the **Armed Forces,** Please speak to a receptionist and **complete a HSCR1 form (Blue form).**

Date of leaving Armed Forces ……………………………………………………………………… DD MM YYYY

Have you attended you own GP within the last year? YES / NO

I ………………………………………………….. agree to comply with the conditions of registration at Loughview Medical Centre and that the information that I have given is accurate.

**PATIENTS SIGNATURE** ………………………………………………………………………………………………………….

**DATE** …………………………………………………………… **DD MM YYYY**

**FOR OFFICE USE ONLY**

Received by ………………………………………………………………… Date ……………………. DD MM YYYY

Approved by Doctors ………………………………………………….. Date ……………………. DD MM YYYY

Recorded on Emis ……………………………………………………….. Date ……………………. DD MM YYYY

New registration appointment (Nurse) booked for ……… Date ……………………. DD MM YYYY