KELTY MEDICAL PRACTICE
NEW PATIENT REGISTRATION – ADULT

NAME ……………………………………..……........… MAIDEN NAME ……………………....……........

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

EMAIL ADDRESS ………………………………………………………………………….......................

Do you give consent to us contacting you from time-to-time via email? Yes / No

DATE OF BIRTH ……………………...……..… PHONE NO. ………………………..................……

MARITAL STATUS Married / Single / Widowed / Divorced / Other

OCCUPATION – Current ………………………........……. Previous ………………….........……..……..

NEXT OF KIN (N.O.K) NAME ....

N.O.K RELATIONSHIP .... N.O.K TEL. NO. ....

ETHNIC GROUP – please circle the most appropriate description:

White Scottish	White English	White Irish	White Northern Irish
White Welsh	White British	White Polish	White Gypsy/Traveller Other
WhitePakistani	Indian	Bangladeshi	Chinese
Other Asian	African	Caribbean	Black
Other African/Caribbean/Black		Mixed ethnic groups	
Arab	Other Ethnic Group	Do Not Wish to Respond	

HEALTH HISTORY
Please list any illnesses, operations or accidents and the year they occurred (if known):

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

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

MEDICATIONS
Name (and strength) Dosage How long taken?

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

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

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

ALLERGIES
Are you known to be allergic or had any upset to medicines? Yes / No

If so, please state the name of the medicine ……………………………………………......................

P.T.O

SMOKING STATUS

Do you smoke? Yes / No If 'yes', how many per day? …………………………………………….

If you are an ex-smoker, how long is it since you stopped? ……………………………………………..

ALCOHOL

Do you drink alcohol? Yes / No If 'yes', how many units per week? ……………………………………

IMMUNISATIONS

Approximate date of last tetanus …………………………………………………………………………

Approximate date of last polio ……………………………………………………………………………

Women only – Approximate date of last Rubella (German Measles) …………………………………

FAMILY HISTORY

Is there a history in your family of any of the following:

Raised blood pressure (hypertension)	Yes / No
Diabetes	Yes / No
Heart disease (e.g. heart attack)	Yes / No
Epilepsy	Yes / No
Other?	…………………………………………………

WOMAN'S SECTION

Are you on an oral contraceptive?	Yes / No

If so, which one? ……………………………………………………………………………………………

Do you have a contraceptive implant fitted?	Yes / No
Do you have an Intrauterine Device (coil) fitted?	Yes / No

If yes, when was implant/coil fitted? ……………………………………………………………………

Have you any children?	Yes / No

How many children? ………………………………………………………………………………………

Have you had a cervical smear test?	Yes / No

Approximate date of last smear test ………………………………………………………………………

Last smear done by: GP / Well Woman or Family Planning Clinic / Hospital