KELTY MEDICAL PRACTICE
NEW PATIENT REGISTRATION – ADULT

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

PREFERRED PRONOUN She/Her He/Him They/Them .....

ADDRESS …….....

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

EMAIL ADDRESS …….....

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. .....

DO YOU HAVE A POWER OF ATTORNEY YES / NO If yes, please provide the practice with a copy

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
Arab	Other African/Caribbean/Black		Mixed ethnic groups
Other Ethnic Group	Do Not Wish to Respond		

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

…….....

…….....…

ARE YOU DIABETIC? YES / NO

IF YES, DIABETIC FOOT RISK IS: Low / Moderate / Severe / Unknown
please circle as appropriate

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

MEDICATIONS

Please list name, strength, dosage and approximately how long taken

…….....

…….....

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 …….....

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? …….....

BLOOD TRANSFUSION (for those born prior to 1996)

Have you had a blood transfusion prior to 1996? Yes / No

The Scottish Government recommends that patients who had a blood transfusion prior to 1996 should be offered a precautionary blood test for Hepatitis C if they have not already been tested.

If you have answered Yes to the previous question, would you like to arrange a blood test appointment to check for Hepatitis C? Yes / No

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

Have you any children? Yes / No How many children? ……

Have you had a cervical smear test? Yes / No Approx. date …….....