Croyard Medical Practice
New Patient Registration Questionnaire

To facilitate your registration process, please complete this form as fully as possible.
Incomplete forms may be returned to you for additional information. Thank you.

PLEASE COMPLETE THE FORM IN **BLOCK CAPITALS**

Surname:

Forename:

DOB:

Address:

Occupation:

Do you have any existing medical conditions or previous surgeries? **YES** (list below) / **NO**

Do you take any medication? **YES** (please list below) / **NO**

(Please attach a slip from your GP or online ordering system to streamline adding your medication to our system)

MEDICATION	STRENGTH	DOSAGE

Do you have any allergies? **YES** (please list below) / **NO**

Next of kin name, address and phone number
For contact in case of an emergency:

Do you have a carer? If so, please provide their name and contact number:

If you have appointed a Power of Attorney, please hand a copy of your Power of Attorney documents into the practice.

Do you smoke? **YES/NO** Current (how many per day?) ☐ Ex ☐ Never ☐

What is your height? ☐ Weight? ☐

Pharmacy		**Please tick**
Muir-of-Ord (Right Medicine Pharmacy)		
Beauly (Boots)		
Conon Bridge (Conon Bridge Pharmacy)		
Drumnadrochit (Great Glen Pharmacy)		
Or to **collect** prescription from reception:	Strathlene surgery, Muir-of-Ord	
	Croyard Road surgery, Beauly	

Please indicate your preferred pharmacy or surgery for collection of prescription/medications:

Fast Alcohol Screening Test (FAST)

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?

0 Never

1 Less than monthly

2 Monthly

3 Weekly

4 Daily or almost daily

How often during the last year have you failed to do what was normally expected from you because of your drinking?

0 Never

1 Less than monthly

2 Monthly

3 Weekly

4 Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0 Never

1 Less than monthly

2 Monthly

3 Weekly

4 Daily or almost daily

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

0 No

2 Yes, but not in the last year

4 Yes, during the last year

I consent to my key medical information being shared with relevant Out of Hours staff:

Name (printed):.....

Date of Birth:.....

Signed:.....Date:.....

For more information about the Key Information Summary (KIS), please see the practice website

For office use only

Received by : Date:

Checked by :

Actions/Appts needed:

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Completed by :