# 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** (please list below) / **NO**

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

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

| MEDICATION | STRENGTH | DOSAGE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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

What is your height? ☐ Weight? ☐

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

Do you drink alcohol? **YES/NO**

Alcohol units per week? ☐ (1 unit= 1/2 pint of beer, small glass of wine or 1 measure of spirits)

**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

☐

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.**

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

| **Pharmacy** | | **Please select one** |
|---|---|---|
| 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 | |

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

*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:

.

.

Completed by :