**KELTY MEDICAL PRACTICE**
**NEW PATIENT REGISTRATION – ADULT**

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

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

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. .....

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 …….....

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 Approx. date …….....