THE FROCESS MEDICAL CENTRE

56 Main Street, Cloughmills, Ballymena BT44 9LF
Telephone No. 028 27638383 Fax 028 2763 8364 E-mail Reception.Z00367@gp.hscni.net
Dr S McCurdy, Dr A McCollum & Dr B Logan

Patient Registration Form Date Received :

Please complete the following details and return this form to reception, along with your medical card. You will be registered with the practice and not with an individual GP. Please complete one registration form per person.

Mr/Mrs/Miss/Ms (delete as appropriate)

FIRST NAMES ______________________________ **SURNAME** ________________________________

CALLING NAME _____________________________ **MAIDEN NAME** _____________________________

ADDRESS __________________________________ **D.O.B** ____________________________________

____ **POSTCODE** ________________________________

HOME TEL NO ______________________________ **MOBILE TEL NO** ____________________________

OCCUPATION _______________________________ **WORK TEL NO** ______________________________

TOWN OF BIRTH _____________________________ **ETHNIC ORIGIN** _____________________________
eg British, Irish, Chinese

PLEASE GIVE REASONS FOR WANTING TO JOIN THIS PRACTICE

____

NAME OTHER RELATIVES (IF ANY) REGISTERED AT THIS PRACTICE

____

PREVIOUS DETAILS

ADDRESS ____________________________ GP/PRACTICE ______________________________

_____________________________________ ADDRESS __________________________________

_____________________________________ PRACTICE TEL NO ___________________________

PAST ILLNESSES (Please tick and give dates where possible)

Measles _____________ Whooping Cough ____________ Mumps ____________ Jaundice ____________

Chicken Pox ________Rheumatic Fever _______________ German Measles ________Other ____________

FAMILY HISTORY – OF ANY OF THE FOLLOWING CONDITIONS (If YES – Please record age of onset of condition)

		MOTHER/age	FATHER/age	BROTHER/age	SISTER/age
Heart Attack	Yes/No				
Angina	Yes/No				
High B/P	Yes/No				
Stroke	Yes/No				
Diabetes	Yes/No				
Breast Cancer	Yes/No				
Prostate Cancer	Yes/No				
Stomach Cancer	Yes/No				
Bowel Cancer	Yes/No				

IMMUNISATION HISTORY – please tick if received and give dates (if possible)

Diptheria __________ Tetanus __________ Polio __________ Hib __________
MMR __________ Typhoid __________ Influenza __________
Rubella (German measles) __________ Pertussis (whooping cough) _________ Measles (single vacc) __________
Other ________________________________

GENERAL (please circle appropriate response)

What operations have you had? ____

Private Health Care? Yes/No

Current Smoker, If yes how many per day? _______________
Ex-smoker? Yes/No If you have stopped smoking when did you give up? _______________
Never smoked? Yes/No

Do you drink alcohol? Yes/No If YES – how many units/drinks per week?
Wine _______________ Beer _______________ Spirits _______________

Do you take Exercise? Yes/No If YES – what and how often ______________________ times per week?

Please list any allergies you have ____

Please describe any special diet you are on ____

Please list any medication you are currently taking:
____

____

Do you suffer from any of the following significant conditions?

CHD	Yes/No	Stroke	Yes/No	Hypertension	Yes/No		
COPD	Yes/No	Diabetes	Yes/No	Hypothyroidism	Yes/No		
Cancer	Yes/No	Epilepsy	Yes/No	Mental Health	Yes/No	Asthma	Yes/No

If YES to any of the above please give details
____
____

Please note: the definition of a carer is someone who is in receipt of a carers allowance, or who is the main carer for an elderly or disabled person whose welfare may be at risk if the carer falls ill.)

Do you have a Carer? Yes/No ***or*** Are you a Carer for someone? Yes/No
If you **have** a carer can you please list their details below:

Name ______________________________ Address ______________________________

Date of Birth _________________________ ______________________________________

Telephone number ______________________

WOMEN ONLY (please circle appropriate response)
Are you taking the Oral Contraceptive Pill? Yes/No
Are you receiving Contraceptive Injection? Yes/No
Do you have a coil fitted? Yes/No If YES when & where was it fitted? _____________________________
____

Give date of last cervical smear _______________ Where was it taken? ____

Have you any children? Yes/No If YES what ages ___________________________
Have you had a HYSTERECTOMY? Yes/No If YES when & where____

THANK YOU FOR COMPLETING THIS FORM

FOR GP COMPLETION

Date of Registration Medical : Medication list request from previous surgery date received:

Welcome date :

Medical Card/ HS200& ID /HSCR1 & ID provided:

Doctor’s Signature ___________________________________ Date ______________________________