HOW TO REGISTER WITH DUNVEGAN MEDICAL PRACTICE

14 years of age and over

Please complete the enclosed forms:
'Application to Register Permanently with a General Medical Practice'
'New Patient Questionnaire'

All boxes marked with * must be completed

CHECKLIST

☐ Have you completed and signed the *'Application to Register Permanently with a General Medical Practice'* form?

☐ Have you completed the '*New Patient Questionnaire'*?

☐ Have you given or withheld consent to share contact details, if necessary, with others involved in your care and signed at that section?

☐ Are you aware of your responsibility to update your contact details including mobile number, should it change?

☐ If you take regular medication, you need to make an appointment with a GP before you can order it for the first time.

Please bring one means of identification per adult (over the age of 18) when returning the forms to reception for checking:

- Photo driving licence
- Utility bill with previous address
- Medical card with previous address
- Passport
- Birth certificate

We may also need to have proof of residency in the UK or entitlement to free NHS Treatment. An administrator can advise you if we need this information.

DUNVEGAN MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE
14 YEARS OLD AND OVER
PAGE 1

Please complete as much information as possible

Have you ever been seen at Dunvegan Medical Centre before? Yes / No

Name	Date of Birth .....
Birth or Other Surname	Preferred Calling Name .....

Do you give permission for contact details to be shared, when necessary, with others involved in your care?	Yes / No
Signature	Date .....

Next of kin (name, address and telephone number) _____

_____

_____

Relationship to you _____

What is your occupation?	
What is your relationship status?	
Do you have any children?	

Health History

Please list any long term conditions you have

Heart Disease	Yes / No	High Blood Pressure	Yes / No
Diabetes	Yes / No	Other:	
Asthma	Yes / No	Other:	
Stroke / CVA	Yes / No		

DUNVEGAN MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE
14 YEARS OLD AND OVER
PAGE 2

Personal Health History

Please tell us about current conditions, past illnesses, accidents, operations or other hospital admissions including, if possible, a date or what age you were.

Illness/condition/accident/operation/admission etc.	Date/age
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Medication

Please list all medication that you take. Please include any medication which is bought from the chemist, or supplied privately.

Name	Dose	Name	Dose
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Please make an appointment with a GP before you run out of your current supply.

Do you have any allergies? Yes / No

Which, if any? .....

Family History

Please list any significant illnesses that run in your immediate family (parents / siblings)

	y/n	Relationship to you:	Age at onset
Heart disease			
Diabetes			
Stroke			
Asthma			
High blood pressure			
Other:			

DUNVEGAN MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE
14 YEARS OLD AND OVER
PAGE 3

Personal Information – We hope that you do not mind completing this section. There may be cultural, religious or lifestyle information in relation to healthcare that we should be aware of.

I would describe my ethnicity as:

White Scottish ¤	Indian ¤	African ¤	Other ¤
White British ¤	Pakistani ¤	Black or Black Scottish ¤	
White Irish ¤	Bangladeshi ¤	Other Asian ¤	
Other White ¤	Chinese ¤	Any mixed background ¤	
	Caribbean ¤	Other ethnic group ¤	

Country of Birth:

UK ¤ Other EEC ¤ Other (Please specify) …….....

Is there anything in relation to your culture, religion, gender, or sexuality that we should be aware of in providing healthcare to you? Yes / No

If yes, please explain: ….……..…..

……..…
Please be assured that this is only relevant to ensure that the care we provide is appropriate.

Personal History

Do you smoke? Yes / No	If yes, how many per day?
If you do not currently smoke, have you ever smoked? Yes / No	When did you stop smoking?
If you smoke, would you like to stop?	Yes / No
...or cut down?	Yes / No
Do you drink alcohol?	Yes / No
If yes, how many units per week? (1 unit + 1 glass wine/0.5 pint beer/1 standard measure of spirits)	units
What regular exercise do you undertake?	
How often?	times per
What is your height?	
What is your weight?	

Firearms

Do you currently hold a firearm or shotgun certificate? Yes / No

If yes, please state what kind of firearm licence you hold (firearm, shotgun, air rifle):

……

When will your licence expire/be due for renewal?

……

Sharing Your Key Information

You can opt to have a Key Information Summary (KIS) activated by us. This allows for your important medical history (main medical conditions, medications, allergies, and next of kin/carer information) to be shared with other NHS colleagues such as NHS 24, the Scottish Ambulance Service and hospitals if you need their assistance.

You can opt out of having a Key Information Summary at any time.

Do you give consent for Dunvegan Medical Practice to create a Key Information Summary (KIS) for you? YES / NO

For office use only

HCA ☐ **ANP** ☐ **GP** ☐

Being a Carer and Being Cared For

Being a Carer	
Do you care for someone?	Yes / No
Do we have your permission to include your name on our carers register and to undertake periodic review of your well-being and support that you may need?	Yes / No
What is your relationship with the person being cared for? ……	
Is the person registered with this practice?	Yes / No
Under the Data Protection Act 2018/General Data Protection Regulation (GDPR), we also need the permission of the person being cared for before recording their name.	
Please advise us of the name and address of the person being cared for:	
NAME ……..	
ADDRESS ……..	

Being Cared For	
Do you have a carer?	Yes / No
Do we have your permission to record in your medical records that you have a carer?	Yes / No
What is your relationship with your carer? ……	
Is this carer registered with this practice?	Yes / No
Under the Data Protection Act 2018/General Data Protection Regulation (GDPR), we also need the permission of the carer before recording their name in your medical record.	
Please advise us of the name and address of the carer below:	
NAME ……..	
ADDRESS ……..	

We will not discuss any aspect of your medical treatment or care with your carer unless we have your permission to do so.

Thank you for taking the time to fill in this questionnaire.