Welcome to Broughty Family Healthcare

Have you been registered at Broughty Family Healthcare previously? Yes No

Please complete as fully as possible. Any questions can be answered at your New Patient Assessment appointment. Please return this form with your completed registration application

Name ....

Address ....

Male / Female .... Date of Birth ....

Home Tel No __________ Mobile Tel No ....

ARE YOU A CARER: YES[ ] NO[ ] IF YES, RELATIONSHIP: NAME: ADDRESS: **DO YOU HAVE A CARER**:YES[ ] NO[ ] IF YES, RELATIONSHIP: NAME: ADDRESS:	**NEXT OF KIN DETAILS:** NAME: RELATION: CONTACT ADDRESS & NUMBER:	**ETHNIC ORIGIN:** WHITE BLACK CHINESE ASIAN MIXED OTHER (PLEASE SPECIFY):

What is your height?	What is your weight? ....

DO YOU SMOKE? ☐ Yes ☐ No IF YES, HOW MANY PER DAY IF AN EX-SMOKER – YEAR STOPPED	**ALCOHOL CONSUMPTION.** ☐ Currently Drink ☐ Ex-Drinker ☐ Lifelong Teetotaller IF YES, HOW MANY UNITS PER WEEK	**WHAT EXERCISE DO YOU UNDERTAKE?**

HEALTH HISTORY

Year (if known) and any major illnesses have you had?

....

....

....

....

....

FAMILY HISTORY

Please detail any serious illnesses / condition which run in your family and the relative (*ie heart disease - mum*)?

....

....

Detail any member of your family and at what age if developed a stroke or heart disease before the age of 60?

....

DRUGS / MEDICINES AND ALLERGIES

Are you taking any medicines or treatments? YES/NO. If "YES" please give details (Please attach repeat prescription slip or list of medications). If unavailable to do this, please detail below.

Name of medicine	How often taken
....	....
....	....
....	....

Are there any medicines of substances that you have reacted to and what was this reaction? YES / NO

If "YES" please give details below.

Name of Medicine	What was the problem or upset
....	....
....	....
....	....

FOR WOMEN

Have you had a cervical smear? YES/No. If "YES", year last done ....

If patient is under FIVE years old: Next of Kin Name: ....

Contact Number .... Mother / Father / Guardian

OTHER INFORMATION

What is your first language : .... Do you require an interpreter: YES / NO

Are you registered disabled – if yes please give details:

Do you hold a Living Will? YES / No

(A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness).

Do you have Power of Attorney in place? Yes / No

If yes, please provide a copy of the documentation for updating your medical records with this information