A picture containing text

Description automatically generated**Croyard Medical Practice**

**New Patient Registration Questionnaire**

We would be very grateful if you could complete this form regarding your medical history to make the registration process as smooth as possible for you.

PLEASE COMPLETE THE FORM IN **BLOCK CAPITALS**

Surname: Address:

Forename:

DOB: Occupation:

Please list your past medical history below, if applicable:

Please list below any medications you are taking:

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

Please list any allergies:

Do you smoke? Please select: Current (how many per day?) Ex Never

If you drink alcohol, how many units do you drink per week?

What is your height? Weight?

Please indicate below your preferred pharmacy or surgery for collection of medications:

|  |  |  |
| --- | --- | --- |
| **Pharmacy** | | **Please tick** |
| 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 |  |

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

*Name (printed):..................................................................................*

*Date of Birth:......................................................................................*

*Signed:...........................................................Date:............................*

*For more information about the Key Information Summary (KIS), please see the practice website.*