**MACLEAN MEDICAL PRACTICE**

WELCOME TO OUR PRACTICE

NEW PATIENT INFORMATION Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By providing your mobile number and email address, you are confirming that it’s ok for us to contact you via these means:-

Mobile number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you wish to register for our online service, please provide photographic ID at reception and we will provide you with a registration document.

Do you smoke? Yes / No If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Yes / No If yes, how many units per week? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a carer? Yes / No

Are you cared for? Yes / No If yes, who is your main carer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin Details: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous operations or illnesses? Please list and include dates:

Are you taking any medication? Yes / No

*If yes, please provide your repeat medication slip from your previous surgery or list below:*

Do you have any allergies? Yes / No If yes, please give details below