**Registration Questionnaire**

Accepted TCI Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Office Use)

It is our practice policy not to prescribe Benzodiazepines (Valium, Xanax, Ativan) If you are on this type of medication please ask to speak to Nurse Holly before filling in this form.

Please fill in both side of this form. If you are unable to fill in and need a little help please ask at reception.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mr Mrs Ms Miss

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PPS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employed Yes No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nationality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year in Ireland if not Irish: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Landline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for leaving GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous GP address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a medical card Doctor visit card or Private?

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Private/Work insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Company name)

Next of Kin name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoker Yes If yes how many daily? \_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_

 No Ex-smoker Years ex\_\_\_\_\_\_\_\_\_\_

Alcohol Yes No If yes how many units (Pint = 2, small glass of wine =1, bottle wine 750 mls =10, single measure spirit – 1 alcopop 275mls = 1, pint cider =3

Drug misuse Yes No Ex Year Ex: \_\_\_\_\_\_\_\_\_\_\_\_ Methadone Yes No

**Medical History:** ( e.g Diabetes, asthma, Heat attack, high Bp, high cholesterol, depression/anxiety, cancer)

Nil Yes Give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Surgical History:** (e.g C section appendix, heart op, cancer op, tonsillectomy)

Nil Yes Give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History of significant medical problems:** (e.g Cancers, heart problems, Diabetes, depression)

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**Current medication:** Please include all medications, applications, dressings, creams, food/drink

You can bring a list from your chemist if you are not sure:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies: Nil Yes Give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children vaccine: Up to date for age (done in Ireland) Not up to date:

If done in another country, please state which country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Only**

Children Yes No If yes how many pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? If yes how many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Cervical screening History smear or HPV:**

Last screening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was it with CervicalCheck? Yes No

Previous treatment? Date and result\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Colposcopy +/- Lletz(lazer) /Biopsy )

**Texting**

Consent to receive text with appointment reminders, info re result (never the result)

I consent Yes No thanks

I will let the practice know if I change my mobile number

I give consent for texting for all my children under 16