Mount Merrion MEDICAL CLINIC

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Registration Form:

Title (Mr/Ms/Mrs etc.) …….. First name……………………………Surname…………………………..
Date of Birth……/…/……….PPS Number…………………………..
Address:………………………………………………………………….EirCode………………………
Gender: Male /Female /Other Birth name (if different)…………………………………………..
Medical Card or Doctor Visit Card Number:…………………….Expiry:…/…/20....

Phone: Home……………………..Mobile……………………………Consent to receive sms Y/N
Email:…………………………………………………….................Consent to receive emails Y/N
Signed:………………………………………..Date:…./…/20…

Emergency Contact/ Next of Kin: Name:…………………………….Relationship:………………..
Telephone No:……………………………………………………….. Consent to contact: Y/N

Previous Doctor/GP:……………………………………………………………………………..
Clinic and address:……………………………………………………………………………….
Phone/Email if known:…………………………………………………………………………….
I consent for the Doctor /Clinic named above to transfer my medical records to Mount Merrion Medical Clinic and also the records of my dependents listed below
Name:…………………………………………………………….Date:…/…./20……
Dependents: *(name and date of birth)*…………………………………………………….
……………………………………………………………………………………………
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Please send the above patients medical records by Healthmail to:
mountmerrionmedicalclinic.gp@healthmail.ie
or by post to:
Mount Merrion Medical Clinic, 71 Deerpark Road, Mount Merrion, Co. Dublin, A94D087

Medical History:

High blood pressure	Yes	No		COPD/ Bronchitis	Yes	No	
Diabetes	Yes	No		Asthma	Yes	No	
Heart disease	Yes	No		Cancer	Yes	No	
Depression/anxiety	Yes	No		Arthritis	Yes	No	
Stroke	Yes	No		Epilepsy/fits	Yes	No	

Other medical conditions:

Operations: ………………………………………………………….. Year…………………………..

Description ………………………………………………………… Year of Diagnosis __________

Description…………………………………………………………. Year of Diagnosis __________

Description…………………………………………………………. Year of Diagnosis __________

♀ Women	♂ Men
Date of last mammogram ____________________ Date of last cervical smear ___________________ Date last cholesterol test _____________________ Date of last bone density (DEXA) scan _________	Date of last PSA ______________________________ Date last cholesterol test ______________________ Date of last bone density (DEXA) scan _________

Allergies:	
Medication:	Food/Other:

Medication: Please include inhalers, patches, creams, contraception and medication doses if known	
1.)	6.)
2.)	7.)
3.)	8.)
4.)	9.)
5.)	10.)

Family History: Please list any medical conditions among your family:

Mother……………………………………………….Father……………………………………………….

Brothers…………………………………………...Sisters……………………………………………….

Occupation:……………………………………………………………………………………..

Smoking: (1)Smoker …/day (2) Ex-smoker - Quit in……*(year)* (3) Never a smoker

Alcohol: Y/N If yes, how many units do you drink weekly? …………………..

Beer (1 pint = 2 units) Wine (125mls glass=1.5 Unit) Spirits (1 glass = 1 Unit)

Signed: ……………………………………………………….. Date:…/…/20…