The Cork Road Clinic
MPHC
Cork Road
Mallow
Co Cork

Phone: 022 - 21579
Fax: 022 - 21986
E-mail: reception@corkroadclinic.ie

Dr Betty Hyde
Dr. Giovanni Baldassini
Dr.Andrew Clare
Dr. Liz Gould
Dr John Veitch

Confidential Patient Registration Form

If there are any sections you prefer not to answer, feel free to leave them blank.

DETAILS:

Title: _____ **Surname:** _______________________ **First Name:**_____________________

Preferred Name: ____________________________

Date of birth: _____/____/____ **Gender:** □ Male □ Female

Home Address: ____

____

Phone: (h) __________________ (w) __________________ (m) ____________________

Email: _________________________________ SMS consent: □ Yes □ No

PPS No: __________________ **Medical card Number**: _________________ **Expiry date:** ___________

Do you have: □ VHI □ LAYA □ Irish Life □ GloHealth □ Garda Medical Aid

Policy Number: ________________________ **Expiry date**: _____________

Occupation: ___________________________________

Ethnicity: _____________________________________

Marital Status: □ Single □ Married □ Defacto □ Separated □ Divorced □ Widowed

Next of Kin (N.O.K.)

Name: ________________________________

Relationship to you: ________________________

Phone: (h) ________________ (w) _________________ (m) __________________

Previous G.P. Details:

Name: _____________________________________

Address: ____

____

Signature of patient or guardian: ____________________________ **Date:** ____________

Print Name: _____________________________

Confidential Medical History Questionnaire

Once completed, please hand this 3 page questionnaire directly to your Doctor.
If there are any sections you prefer not to answer, feel free to leave them blank.

Patient Name: ______________________________ **Date of birth**: ____/____/____

What do you wish to discuss with your doctor today?

____

____

What outcome would you like to achieve by the end of your consultation today?

____

Past Medical History

Have you suffered from any of the following?

- ☐ Heart Attack
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Blood Clot(s)
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Anxiety or Depression
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Epilepsy
- ☐ Fracture

Past Surgical History

- ☐ Appendix
- ☐ Tonsillectomy
- ☐ Treatment of fractured bones
- ☐ Other

Please list current and past serious illnesses, operations, hospital admissions. (if none, write NIL)

YEAR	DETAILS

Current medication:
Please include ALL tablets, inhalers, patches, gels or injections - As well as the pill and any 'natural' remedies such as vitamins, herbal remedies, homeopathic remedies and supplements.

NAME OF MEDICATION	DOSE (if known)

Allergies:
Do you have any allergies or are you sensitive to drugs or dressings?

ALLERGY	REACTION

Family History:

Has anyone in your close family suffered from the following? - include the relative affected, eg. Mother, Sister.

DISEASE	RELATIVE & AGE AFFECTED		DISEASE	RELATIVE & AGE AFFECTED
Heart Disease (eg. heart attack, stent, bypass surgery)			Bowel Cancer	
High Blood Pressure			Ovarian Cancer	
Stroke			Melanoma	
Blood clot (s)			Prostate	
Diabetes			Any other cancer	
Thyroid Disease			Asthma	
Osteoporosis			Depression	
Breast Cancer				

Lifestyle:

□ Tobacco: ________ day / week or ceased smoking—date ____/____/____
□ Alcohol: _________ day / week / month (circle the one applicable)
□ Drug use: ____ (type and frequency)

For women

Preventative Health

When was your last Pap smear taken? ______________________________
Normal/Abnormal

If you have ever had an abnormal Pap smear, please give details:
____

When was your last Mammogram? ______________________________________

Number of pregnancies? ______________________________________

Number of children? ______________________________________

Immunisations

Have you received immunisation against the following disease?

- ◻ Rubella ◻ Chickenpox ◻ Hepatitis A ◻ HPV (Gardasil/Cervarix)
- ◻ Tetanus ◻ Polio ◻ Hepatitis B ◻ Meningococcal Disease

For patients 65 years old or over
◻ Influenza ◻ Pneumococcal Disease

Signature of patient or guardian: ______________________________ **Date:** _____________

Print Name: _______________________________

TRANSFER OF MEDICAL RECORDS

Doctor's Name: ___________________________________

Address:____

RE: **DOB:**

I authorise transfer of my medical records to the above practice.

Signed:____________________________ Date:

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Dear Doctor,

The above patient has requested transfer of their medical records to this practice.
They can be forwarded via healthmail : corkroadclinic.gp@healthmail.ie

We would be grateful if this could be arranged, at your earliest convenience, to facilitate ongoing care.

Yours sincerely,

The Cork Road Clinic