



(May 2019 Version)

**Please complete all sections of this form in their entirety
The completion of this form is essential for our records.**

PLACE OF BIRTH:	
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SECTION B - HEALTH STATUS INFORMATION

SMOKING STATUS - Have you ever smoked?	Yes/No
If Yes, are you a current smoker?	Yes/No
If Yes, how many do you smoke per day?	_____
If Yes, please see additional handout given by receptionist.	
ALCOHOL STATUS - Do you drink alcohol?	Yes/No
If Yes, how many units would you drink per week?	_____

☐ SHORT STAY - UP TO 15 DAYS ☐ EMERGENCY TREATMENT
☐ LONG STAY - 16 DAYS TO 3 MONTHS ☐ IMMEDIATELY NECESSARY TREATMENT
☐ TELEPHONE SERVICES ONLY DATE OF INITIAL TREATMENT _____
 CONTRACEPTIVE SERVICES ☐ IUD ☐ NON IUD

Date of Registration:	
EMIS Number:	Your Initials:
LONG STAY/SHORT STAY	EXPIRY DATE:

TEMPORARY RESIDENT FORM

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SECTION C - MEDICAL HISTORY

Do you suffer from -	Asthma	Yes/No
	Heart Disease	Yes/No
	Diabetes	Yes/No
	Stroke	Yes/No
	Epilepsy	Yes/No
	COPD/Bronchitis	Yes/No
	Thyroid Problems	Yes/No
	High Blood Pressure	Yes/No
	Any other significant medical condition?	Yes/No
If you answered Yes to any of the above, please list your current medication		
Medication	Strength	Dose

Castle Practice participates in the Department of Health led Benzodiazepines Reduction and Opiodes Reduction programme.

Patients should be aware that prescriptions and medications will be reviewed in line with the Department of Health Guidelines.

PLEASE TICK HERE TO CONFIRM YOU HAVE READ THIS NOTICE

☐

ALLERGIES - Please list any known allergies you have to medication (ie penicillin)

VACCINATIONS - Please list any know vaccinations received in the last 10 years

WOMEN ONLY - When was your last cervical smear? Date: _____
If you are currently being prescribed contraception, please circle accordingly:

IUD (coil) Pill Depo-Provera Injection Implanon

CHECK LIST - FOR COMPLETION BY RECEPTION

Checked EU/Non EU Country	Yes	Date:	_____	(initial)	_____
Photographic ID copied	Yes	Date:	_____	(initial)	_____
Visa/Permit copied (if necessary)	Yes	Date:	_____	(initial)	_____
GP Alerts Database checked	Yes	Date:	_____	(initial)	_____
Ethnic Origin coded	Yes	Date:	_____	(initial)	_____
Smoking Status/Alcohol Status Coded	Yes	Date:	_____	(initial)	_____
Smoking Information Leaflet Given (if smoker)	Yes	Date:	_____	(initial)	_____

