

Do you have any special communication needs? Yes No

If yes: Sign Language Large Print Other

.....

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: Mr Mrs Miss Ms Male Female

Date of Birth (day/month/year) NHS Number

Town & country of Birth

Address
Post Code:

Telephone number: Mobile number:

Email address:

Please help us trace your previous medical records by providing the following information:

Your previous address in UK
Post Code:

Name of previous Doctor while at that address

Address of previous Doctor
Post Code:

Where did you last receive treatment? Date:

ie GP, Walk in Centre, MIU, Emergency Department etc

What was the outcome of this visit? ie prescription

If you are from abroad:

Your first UK address where Registered with a GP
Post Code:

If previously resident in UK date of leaving Date you first came to UK

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

I live more than 1 mile in a straight line from the nearest chemist

Have you or any member of your immediate family ever served in the British Armed Forces (spent at least one day enlisted):

Yes, I'm currently serving at:

Yes, I am a military veteran:

Yes, I am a member of a military family:

Enlistment date(s) Service/ Personnel number

NHS Organ Donor registration:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue or
- Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.
For more *information please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk or call 0300 123 23 23*

NHS Blood Donor registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)

..... Post code:

Please tell us about yourself:

Are you a carer? Yes No Do you have a carer? Yes No

If yes, please tell us the name & address of your Carer:

Are you happy for us to contact your carer about you? Yes No

For patients aged 85 or over: (these are to help us assess if you may need additional clinical input)

- In general, do you have any health problems that require you to limit your activities? Yes No
 In general, do you have any health problems that require you to stay at home? Yes No
 Do you regularly use a stick, walker or wheelchair to get about? Yes No
 In case of need, can you count on someone close to you? Yes No
 Do you need someone to help you on a regular basis? Yes No

Please provide details if the person is different from the information you have provided as your carer.

Personal Medical History.....

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing Yes/No
		Yes/No
		Yes/No
		Yes/No

Family History.....

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations

Immunsation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

--	--

Lifestyle

Please enter your height & weight:

Height:	Weight:
---------	---------

Lifestyle smoking

Do you smoke: Yes No

If yes, do you smoke: Cigarette Cigars Pipe

Are you an ex-smoker? Yes No

When did you give up?

How many cigarettes/ cigars do you smoke daily? <1/day 1-9/day 10-19/day 20-39/day 40+/day

If you smoke a pipe how many ounces a week?

Would you like help Yes No to quit smoking?

Lifestyle alcohol

Do you drink alcohol: Yes No If yes, please answer the following questions:

How often do you have a drink that contains alcohol? Never Monthly 2-4 times 2-3 times 4+ times
Or less per month per week per week

How many standard alcoholic drinks do you have on a typical day when you are drinking? 1-2 3-4 5-6 7-8 10+

How often do you have 6 or more standard drinks on one occasion? Never Less than Monthly Monthly Weekly Daily or almost daily

Lifestyle exercise

Do you exercise: Yes No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

Female patients only

Are you currently, or think you may be pregnant? Yes No

Do you have any children? Yes No If yes, how many?

Which method of contraception (if any) are

you using at present?

Have you had a cervical smear test?

Yes No

If yes, what was the
result? (if known)
Date (if known)

Ethnicity

Please indicate your ethnic origin:

- British or mixed British Irish African Caribbean Indian Pakistani
 Bangladeshi Chinese Other (please state):
 Decline to state

Next of kin

Name:

Tel. contact
number:

Relationship:

Data sharing consent choices

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email

Yes No

This will be to send you letters, newsletter and the like

By text

Yes No

This will be to send you reminders of appointments via text

Signature

I confirm that the information I have provided is true to the best of my knowledge.

Signed:

Date:

Signature of patient Signature on behalf of patient