Silton Surgery

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other

……

CONFIDENTIAL MEDICAL REGISTRATION FORM ADULT

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

If you are returning from the Armed Forces:

Addresss before enlisting

Post Code:

Enlistment date

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

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 to quit smoking? ☐ Yes ☐ No

Lifestyle alcohol ……

How often do you have a drink containing alcohol? Please circle the answer that applies to you.				
N/A or Never (0)	Monthly or less (1)	2-4 times a month (2)	2-3 times a week (3)	4 or more times a week (4)

How many drinks, containing alcohol, do you have on a typical day when you are drinking?					
None	1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)

How often during the past year have you found that you were not able to stop drinking once you had started?				
N/A or Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)

How often during the past year have you failed to do what was normally expected of you because of drinking?					
N/A	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)

Has a relative, friend, doctor or other health worker, been concerned about your drinking or suggested you cut down?					
N/A	No (0)	Yes, but not in the past year (2)	Yes, during the past year (4)		

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? Please circle the answer/s that applies to you.				
N/A or Never (0)	Monthly or less (1)	Monthly (2)	Weekly (3)	Daily or almost daily?(4)

Alcohol screen – AUDIT PC Completed TOTAL:

(For Practice Nurse to complete)

Patient Participation Group (PPG)

The aim of the PPG is to give patients the opportunity to voice what matters to them. We encourage members to give feedback on the service provided. If you would like to contribute please tick here: ☐

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 ……

WRITE FIRST LANGUAGE IN BOX :

Please also Tick box to indicate your ethnic origin:

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

Next of kin ……

Full Name: Tel. contact Number/s:

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 Silton Surgery 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 ☐

Reviewed and amended 22.08.2016