CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Name:

Mobile:

Email

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 (Please note: both parties will need to sign a consent form from Reception)

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

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

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 ……

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 Or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times 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 state your ethnic origin:

What is your first language:

Next of kin ……

Name: Phone number

Address: Mobile 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 overleaf the 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 boxes below and read the form attached.

Title …… **Given Name** …….. **Surname** …….

Post Code ……. …… **House Number** ……..

Signature …… **Date** ……

Please **opt me out** of sharing my record from the practice with others involved in my care *(9NDO)*: ☐

Please **opt me out** of sharing my record with other NHS organisations for unplanned care **Summary Care Record** *(9NDQ)***:** ☐

Please **opt me out** of my health data leaving the GP practice for **Care.Data** *(9Nu0)***:** ☐

Patient Reference Group

The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for making services better. We send information emails regarding the practice such as our quarterly newsletter and also pertinent information about local health services. At times we will also request feedback and a response from patients. You are in no way obliged to respond but it does help us to develop our services for you. If you provide us with your email address we will automatically add you to the group unless you tell us not to.

No, I am not interested in receiving information from the practice or being part of the Practice Patient Reference Group (Please tick the box) ☐

Communications: if it is ok for us to leave messages on your home answerphone please tick:

What is your preferred contact method: □ text □ email □ letter □ phone call

Do you have special communication needs? □ braille ☐ large print ☐ interpreter ☐ easy read

☐ lip reading ☐ speech to text reporter (STTR) ☐ advocate ☐ British Sign Language BSL

If you need interpretation, what is your first language?

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 ☐