CONFIDENTIAL MEDICAL REGISTRATION FORM

If you would like this letter or other information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call us on 01962 852211 or email on whccg.stclementssurgery@nhs.net.

Alternatively, you can also indicate your communication needs using the space below:

My communication needs are:

Braille:
Large Print:
British Sign Language:
Other (please state):

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 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*

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 ……

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 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 and share **certain** medical information so that it is available to other healthcare professionals/organisations (eg Emergency Departments, Community Care Services or agencies involved in your direct care). The information shared is basic medical information; such as your prescriptions, allergies, recent test results and your NHS number. If you do not wish to share this information; please ask for and complete an **OPT-OUT FORM** that is available from the surgery.

Where you have provided information on how to contact you, can you confirm you are happy for St Clements 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

Electronic Prescription Service

St. Clements Practice uses the Electronic Prescription Service. If you have previously used this service, and wish to continue, you are reminded that it is your responsibility to ensure you nominate a local pharmacist to allow us to dispense your medication.

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 ☐

PLEASE NOTE THAT REGISTRATION FORMS MUST BE ACCOMPANIED BY PROOF OF CURRENT RESIDENCE (i.e. driving licence, utility bill, bank statement dated within the last 3 months)

PLEASE REMEMBER TO LET US KNOW IF YOU HAVE ANY SPECIAL COMMUNICATION NEEDS