CONFIDENTIAL MEDICAL REGISTRATION FORM

IDENTIFICATION IS REQUIRED FOR REGISTRATION

Please provide 1 x photo ID and 1 x address ID, this may be in the form of a passport/driving license/citizen card or utility bill.

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:

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

Military Veterans

Please tick this box if you have previously served in the armed forces. ☐

Please tell us about yourself:

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 Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer Please Specify:

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:
BP:	

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? ☐

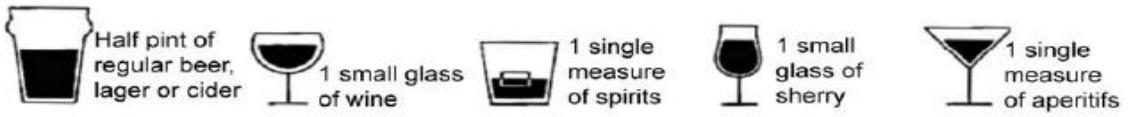
How many cigarettes/ cigars do you smoke daily? ☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe how many ounces a week? ☐

Would you like help to quit smoking? ☐ Yes ☐ No

Lifestyle alcohol ……

This is one unit of alcohol…



…and each of these is more than one unit

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 units of alcohol do you drink 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 units if female or 8 or more if male, on a single occasion? ☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily

Lifestyle exercise ……

How often do you exercise?

No exercise:	☐ Yes	☐ No
Light exercise 1-3 times per week	☐ Yes	☐ No
Moderate exercise: 3-5 times per week	☐ Yes	☐ No
Heavy exercise: 5+ times per week	☐ Yes	☐ No

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: _____

Carers

Do you act as a carer for anyone? YES/NO

If Yes: Name: …… Dob ……..

Address …….

Are they registering/ed with this Practice? YES/NO

Data sharing consent choices ……

Summary Care Record(SCR)

There is a new Central NHS Computer System called the Summary Care Record (SCR). It is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had to support your emergency care. Only healthcare staff involved in your care can see your Summary Care Record.

Please sign here if you are happy for data to be shared: Signature……
You are allowed to opt out - Opt out forms can be found on our website www.stoursurgery.co.uk or please ask at reception.

Additional Information for your Summary Care Record(SCR)

You can also choose to include more information in your SCR such as significant medical history, immunisations, patient preferences and particular care needs. Please ask at reception for an information leaflet.

Please sign here if you are happy for additional information to be added to your SCR: Signature……

Shared Data

On occasion, information may need to be shared with other staff or organisations in order to help them decide the best care and treatment available.

Other organisations may include District Nurses, Health Visitors etc. or other service providers commissioned and appointed by the CCG that are committed to the improvement of health outcomes for patients.

When members of staff from different organisations are involved they will only be allowed access to information that is relevant to the purpose of their job/role and will not necessarily have access to your medical history.

If you would like to OPT OUT of shared data please sign here: Signature……

Contacting You…….

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

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 visit the website www.uktransplant.org.uk or call 0300 123 23 23*

Signature…….…… Post code: …….

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 visit the website www.blood.co.uk My preferred address for donation is (only if different from above eg your place of work)

Signature…….…… Post code: ……..

Online Access

If you would like to use online access for renewing your prescription, booking a call back with your GP or viewing part of your medical record, please complete the attached application form.

Named Accountable GP

We are required to allocate all patients at this practice with a named GP who is responsible for your overall care. Our reception staff will advise you at time of registration who this will be, however if you have a preference as to who this is we will make reasonable efforts to accommodate your request.

Accessible Information

We want to get better at communicating with our patients. We want to make sure you can read and understand the information we send you. If you find it hard to read our letters or if you need someone to support you at appointments, please let us know. We want to know if you need information in braille, large print or easy read.

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 ☐