BURGESS ROAD SURGERY

CONFIDENTIAL MEDICAL REGISTRATION FORM - ADULTS (16+)

Personal Details:

Please complete all pages in FULL using BLOCK capitals

Surname:

First Names (in full):

Previous Surnames:

Title: ❒ Mr ❒ Miss ❒ Ms ❒ Male ❒ Female

Date of Birth (day/month/year):

NHS Number: (if known)

Town & Country of Birth:

Address:

Post Code:

Telephone Number: Mobile Number:

Email Address:

Occupation

Marital Status

Would you like Online Access? ❒ Yes ❒ No

Do you have any special communication / mobility needs? ❒ Yes ❒ No
If yes please state:

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

Your previous address in the UK:

Post Code:

Name of previous Doctor while at that address:

Surgery Name and 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 the UK:

Personal Medical History:

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below (if extra space is required please use box at end of form):

Condition	Year Diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family Medical History:

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

	Heart Disease	Stroke	Diabetes	High Blood Pressure	Asthma	Glaucoma	Cancer	Mental Health Problems	Renal/ Kidney	Learning Difficulties
At the time of diagnosis they were:										
Over 60 yrs old										
Under 60 yrs old										

List of Current Medication: (inc contraception)

Name of Medication	Dosage

Allergies:

Please list any allergies you have to any drugs/medications or if known egg allergy or peanut allergy:

Name of Medication	What was the problem or upset?

Height _____ **Weight** _____

Do you Smoke? ❒ Current Smoker ❒ Ex-Smoker ❒ Never Smoked
If YES, how many per day ……

Vaccinations

❒ Diphtheria ❒ Polio ❒ Tetanus ❒ Measles ❒ MMR ❒ German Measles
❒ Whooping Cough ❒ Meningitis ❒ BCG ❒ Hep A ❒ Hep B ❒ Typhoid

Ethnicity:

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

Language:

Main spoken language: _____
Do you need an interpreter? ❒ Yes ❒ No

Data Sharing Consent Choices:

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations for medical reasons (eg Emergency Departments). If you wish to **OPT OUT** of this please inform reception.

Are you happy to share your medical information with other NHS providers? ❒ Yes ❒ No
Are you happy to share your anonomised medical information for clinical research? ❒ Yes ❒ No
Would you like to join our patient participation group (email address required) ❒ Yes ❒ No

Signatures:

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

Name Date:

Signed

Office Use Only

Health Check Appointment Date & Time…….. Nurse……

GP Appointment Date & Time……GP ..……..