Combe Down Surgery

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals

Surname:

First Names (in full):

Previous Surnames:

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: ☐ 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:

i.e. GP, Walk in Centre, MIU, Emergency Department, etc.

What was the outcome of this visit? i.e. prescription.

If you are from abroad:

Previous address abroad:

Country:

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:

I would like to collect my prescription from:

☐ Lloyds Combe Down ☐ Lloyds Odd Down ☐ Dudley Taylor ☐ Wellsway Pharmacy

☐ Other:

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

Signed: Date:

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 ☐

Signed: Date:

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

Immunisations:

Immunsation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

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
		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

If appropriate, please give further information (eg, age of diagnosis, type of Cancer, etc):

Allergies:

Name of medication or allergen:	What was the problem or upset?

List of current medication:

Please attach a copy of any repeat medications, or ask reception to make a copy when registering.

Please note: Repeat medications will not be continued until reviewed by a doctor. If you have any medications that will need reissuing in the next 2 weeks you must inform reception, otherwise there will be a delay in collecting this medication.

Name of medication:	Dosage: (strength, and how often)

Lifestyle – Height and weight:

Please enter your height & weight:

Height:	Weight:

Lifestyle - Smoking:

Do you smoke: ☐ Yes ☐ No

Are you an ex-smoker? ☐ Yes ☐ No If yes, when did you give up? _____

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? ☐ 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:

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 ☐ Chinese

☐ Romanian ☐ Polish ☐ Other (please state): _____

☐ Decline to state

Next of kin:

Name: _____ Telephone number: _____

Relationship: _____

Data sharing consent choices:

To ensure you receive the best continuity of care, we upload certain medical information so that it is available to other healthcare organisations (eg. Emergency Departments or Out-of-Hours doctors). Should you wish to know more about how and what type of information is shared and what your options are regarding the sharing of any information, please ask at reception for a 'Data Sharing' information leaflet. Please be aware that we will assume you consent to share your patient data unless you instruct us otherwise.
If you wish to **OPT OUT** please complete the form at the end of the leaflet and give to reception.

Online Services Information:

You can book GP appointments and request repeat prescriptions online. You will need to obtain a log-on code and password from Reception. For your own security you must bring photographic ID. You must be registered before you switch to online medication requests.

Contact via text and email:

Where you have provided information on how to contact you, can you confirm you are happy for Combe Down Surgery to contact you by the following:

By email ☐ Yes ☐ No
By text ☐ Yes ☐ No

Communication / information needs:

Do you have any communication / information needs relating to a disability or sensory loss and if so what are they?

Would you be happy for us to share your communication/information needs as part of our existing data sharing processes? ☐ Yes ☐ No

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 ☐

For internal use only:

2 items of ID seen: Photo ☐ Address ☐

Seen by (initials): Date:

Updated 07/04/17