



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  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

**I would like to collect my prescription from:**

Lloyds Combe Down

Lloyds Odd Down

Dudley Taylor

Wellsway Pharmacy

**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](http://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

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

*For more information, please ask for the leaflet on joining the NHS Blood Donor Register.*

My preferred address for donation is (only if different from above eg your place of work)

..... Post code: .....

**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	Immunsation	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:
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**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  Yes  No to quit smoking?

### 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  2-4 times  2-3 times  4+ times  
Or less per month per week 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 **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying 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 form found with this leaflet.

**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.

**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

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

**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