**Please complete all pages in FULL using BLOCK capitals, and return to Reception with photo ID and proof of address**

Address

**Post Code:**

Place of Birth

NHS Number (If known)

Date of Birth

**Title:** Mr Mrs Miss Ms Other Male Female

**ST ANDREW’S SURGERY CONFIDENTIAL MEDICAL REGISTRATION FORM**

Forenames (In Full)

Surname

Previous Surnames

Contact Number(s)

Email Address:

Will you use a translator?

What is your first language?

Date of UK entry

First UK address

where registered

with a GP

**Post Code:**

**If you are originally from abroad:**

Previous GP address

**Post Code:**

Name of previous GP

Previous UK address

**Post Code:**

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

Address before

enlisting

**Post Code:**

**If you are returning from the Armed Forces**

Service/personnel no.

Enlistment date

**NHS Organ Donor registration**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissues can be used for transplantation after my death. Please tick the boxes that apply.

Any of my organs and tissue

Kidneys Heart Liver Corneas Lungs Pancreas

Signature to confirm agreement to donation is at the bottom of this form.

For more information please visit [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 agreement to donation is at the bottom of this form.

For more information please visit [www.blood.co.uk](http://www.blood.co.uk).

**Data sharing consent**

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.

If you wish to **OPT OUT** please complete the form found with this leaflet.

In order to provide high quality healthcare and to communicate effectively with patients the surgery would like to use all available communication methods (including but not limited to; appointment reminders, results, health recalls). Where you have provided information on how to contact you, please indicate below if you do **not** consent to be sent information by the surgery.

I do **not** consent to be sent information by email

I do **not** consent to be sent information by text

I confirm that the information I have provided is true to the best of my knowledge

Signature of patient Signature on behalf of patient



Date

Signature

**Signature**



|  |  |  |
| --- | --- | --- |
| **Condition** | **Year Diagnosed** | **Ongoing?** |
|  |  |  |
|  |  |  |
|  |  |  |

In order to provide the best healthcare we can, it is helpful to know some information about you and your medical history.

Are you a carer? Yes No Do you have a carer? Yes No

If yes, please tell us the name and address of your carer

Are you happy for us to contact your carer about you? Yes No

In general, do you have any health problems that require you to limit your activities? Y N

In general do you have any health problems that require you to stay at home? Y N

Do you regularly use a wheelchair, stick or walker to help you get around? Y N

Do you need someone to support you on a regular basis? Y N

Please provide details if the person is different from the carer information

Have you ever suffered from any significant medical illness, operation or hospital admission? If so please enter details below:

**Personal Medical History**

**Further information: to help us assess if you may need additional clinical input**

**Name:**

**Address:**

**Please tell us about yourself:**

**Family History**

Have any close relatives (father, mother, sister, brother) ever suffered from any of the following?

Please indicate who in the boxes below

Are you a carer? Yes No Do you have a carer? Yes No

If yes, please tell us the name and address of your carer

Are you happy for us to contact your carer about you? Yes No

In general, do you have any health problems that require you to limit your activities?

In general do you have any health problems that require you to stay at home?

Do you regularly use a wheelchair, stick or walker to help you get around?

Do you need someone to support you on a regular basis?

Please provide details if the person is different from the carer information

Have you ever suffered from any significant medical illness, operation or hospital admission? If so please enter details below:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart Attack | Stroke | Diabetes | High Blood Pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

**Immunisations**

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunisation** | **Year** | **Immunisation** | **Year** |
| Tetanus |  | Polio |  |
| Typhoid |  | Yellow Fever |  |
| Hepatitis A |  | Hepatitis B |  |

Please list any allergies you have to any drugs/medication:

Are you a carer? Yes No Do you have a carer? Yes No

If yes, please tell us the name and address of your carer

Are you happy for us to contact your carer about you? Yes No

In general, do you have any health problems that require you to limit your activities?

In general do you have any health problems that require you to stay at home?

Do you regularly use a wheelchair, stick or walker to help you get around?

Do you need someone to support you on a regular basis?

Please provide details if the person is different from the carer information

Have you ever suffered from any significant medical illness, operation or hospital admission? If so please enter details below:

**Allergies**

|  |  |
| --- | --- |
| **Name of medication** | **Reaction** |
|  |  |
|  |  |

If you have a copy of your repeat medication, please pass it to Reception to copy

Are you a carer? Yes No Do you have a carer? Yes No

If yes, please tell us the name and address of your carer

Are you happy for us to contact your carer about you? Yes No

In general, do you have any health problems that require you to limit your activities?

In general do you have any health problems that require you to stay at home?

Do you regularly use a wheelchair, stick or walker to help you get around?

Do you need someone to support you on a regular basis?

Please provide details if the person is different from the carer information

Have you ever suffered from any significant medical illness, operation or hospital admission? If so please enter details below:

**List of current medication**

|  |  |
| --- | --- |
| **Name of medication** | **Dosage** |
|  |  |
|  |  |

**Lifestyle**

|  |  |
| --- | --- |
| **Height:** | **Weight:** |

**Lifestyle… Smoking**

Do you smoke? Yes No If yes do you smoke: Pipe Cigarettes Cigars

How many cigarettes/cigars do you smoke daily?

If you smoke a pipe or roll cigarettes, how many ounces of tobacco do you smoke per week?

Would you like help to quit smoking? Yes No

Are you an ex-smoker? Yes No When did you give up?

Are you happy for us to contact your carer about you? Yes No

In general, do you have any health problems that require you to limit your activities?

In general do you have any health problems that require you to stay at home?

Do you regularly use a wheelchair, stick or walker to help you get around?

Do you need someone to support you on a regular basis?

Please provide details if the person is different from the carer information

Have you ever suffered from any significant medical illness, operation or hospital admission? If so please enter details below:

**Lifestyle… Alcohol consumption**

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 a month 2-3 times a week 4+ times a week

How many standard alcoholic drinks do you have on a day when you are drinking?

1-2 3-4 5-6 7-8 9+

How often do you have 6 or more standard drinks on one occasion?

Never Less than monthly Monthly Weekly Daily

**Ethnicity**

Are you currently or could you be pregnant? Yes No

Do you have any children? Yes No If yes, how many?

If you are currently using contraception, what method are you using?

Have you ever had a cervical screening test (smear)?

Yes No If yes, what was the result?

When did you have it?

Do you exercise? Yes No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

**Additional Information**

**Lifestyle… Exercise**

Please indicate your ethnic origin (ethnicity list sourced from UK Government Guidance 2020)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **White** |  | **Black** |  | **Asian** |  | **Mixed** |  | **Other** |  |
| British |  | African |  | Indian |  | White and Asian |  | Arab |  |
| Gypsy or Irish traveller |  | Caribbean |  | Pakistani |  | White and Black African |  | Any other ethnic group |  |
| Irish |  | Other |  | Bangladeshi |  | White and Black Caribbean |  | Decline to state |  |
| Other White background |  |  |  | Chinese |  | Other mixed background |  |  |  |
|  |  |  |  | Other Asian background |  |  |  |  |  |

**Next of Kin (Emergency Contact)**

Name:

Relationship to you:

Contact number:





