Brookfield Park Surgery

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……

LARGE PRINT

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

Sex: ☐ 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?

ie GP, Walk in Centre, MIU, Emergency Department etc

Date of this:

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 UKdate 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	

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 yourCarer:

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

For patients <u>aged 75 or over</u>: (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	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

Name of medication	Dosage

Lifestyle ……

Please enter your height & weight:

Height:	Weight:
Blood Pressure:	Waist Circumference: cm

Occupation:

Full Time/Part Time/Unemployed/Housewife-Husband/Retired/Stident (Please Circle)

Marital Status:……

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐ No
If yes, do yousmoke: ☐ 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 ……

Do you drink alcohol: ☐ Yes ☐ No
How many units per week (please see the unit chart on the wall in reception/ attached): Units/week

If yes, please answer the following questions:

How often do you have a drink that contains alcohol?
☐ Never (0) ☐ Monthly or less(1) ☐ 2-4 times per month(2)
☐ 2-3 times per week (3) ☐ 4+ times per week(4)

How many standard alcoholic drinks do you have on a typical day when you are drinking?
☐ 1-2(0) ☐ 3-4(1) ☐ 5-6(2) ☐ 7-9 (3) ☐ 10+(4)

How often do you have 6 or more standard drinks on one occasion?
☐ Never (0) ☐ Less than monthly (1) ☐ Monthly (2)

☐ Weekly (3) ☐ Daily or almost daily (4)

TOTAL SCORE =

Lifestyle exercise ……

What exercise do you do?
Heavy/Moderate/Light/No Exercise (please circle)

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) areyou 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:

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

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 ☐