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

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

LARGE PRINT
CONFIDENTIAL MEDICAL REGISTRATION FORM
(CHILDREN UNDER 16)

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:

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	

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 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: ……

Personal Medical History…..

Type of Birth:
(eg normal, forceps, CaesareanIf under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed if under 5)

Has your child 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: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Please provide details of your childs immunisations with dates if possible (under 5's). If possible please give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles		BCG (TB)	
MMR		Meningitis	

List of current medication ……

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

Name of medication	Dosage

Allergies ……

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

Name of medication	What was the problem or upset?

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

Signed: _____ Date: _____

Signature on behalf of patient ☐ Signature of patient ☐