Newbury Group Practice

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

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

**CONFIDENTIAL MEDICAL REGISTRATION FORM**

**Please complete all \* asterix & please complete pages in FULL using BLOCK capitals**

Title **\***: 🞏 Mr 🞏 Master 🞏 Mrs 🞏 Miss 🞏 Ms 🞏 Male 🞏 Female

|  |  |
| --- | --- |
| Surname\* |  |

|  |  |
| --- | --- |
| First Names (in full)\* |  |

|  |  |
| --- | --- |
| Previous Surname\* |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of Birth  (day/month/year)\* |  | NHS Number\* |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Town & Country of Birth\* |  | Ethnicity |  |

|  |  |
| --- | --- |
| Current Address\* | Post Code: |

|  |  |
| --- | --- |
| Your previous address in the UK\* | Post Code: |

|  |  |  |  |
| --- | --- | --- | --- |
| Telephone Number\* |  | Mobile Number |  |

|  |  |
| --- | --- |
| Email address\* |  |

\*Age 11-15 I have consent for my contact detail to be the same as my parent’s contact details

Under the new data protection law (GDPR) we have to ask for consent regarding contact detail please tick the box Yes Signature of child

**If you are from abroad:**

If previously resident in UK Date you first

date of leaving \* came to UK\*

(Day/Month/Year)

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

Name of previous Doctor

while at previous address\*

Post Code:

Address of previous Doctor\*

**Please tell us about yourself:**

Are you a carer\*? 🞏 Yes 🞏 No Do you have a carer\*? 🞏 Yes 🞏 No

|  |
| --- |
| **What is carer?**  You are a carer if you provide help and support, unpaid, to a family member friend or neighbour who would otherwise not be able to manage.  The person you care for may have a physical or learning disability, dementia, mental health problems, may misuse drugs or alcohol or may be ill or frail etc.  The person may live with you or elsewhere, may be an adult or a child but if they rely on you for support, then **you are a carer.** |

If yes, please tell us the name & address of your

Carer:

Are you happy for us to contact your carer 🞏 Yes 🞏 No

about you?

Who do you care for:

**Personal And Family Medical History…..**

Have you and your close relative ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease** | **Personal Medical History** | **Year diagnosed** | **Ongoing (Yes/No)** | **Family Medical History**  **(father, mother, sister, brother only)** |
| Heart Attack |  |  |  |  |
| Stroke |  |  |  |  |
| Diabetes |  |  |  |  |
| High blood pressure |  |  |  |  |
| Asthma |  |  |  |  |
| Glaucoma |  |  |  |  |
| Cancer |  |  |  |  |

**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 send a copy with documents or complete below:

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

**Electronic Prescription Consent ……**

This will allow electronic transfer of your prescription direct to your pharmacy of choice.

|  |  |
| --- | --- |
| Nominated pharmacy address\* | Post Code: |

|  |  |
| --- | --- |
| **Lifestyle** | |
| **smoking** | **Alcohol** |
| Do you smoke: 🞏 Yes 🞏 No  **If yes**, How many cigarettes/  do you smoke daily?  🞏 <1/day 🞏 1-9/day 🞏 10-19/day  🞏 20-39/day 🞏 40+/day  Would you like help 🞏 Yes 🞏 No  to quit smoking?  **If no**, Are you an ex-smoker? 🞏 Yes 🞏 No    When did you give up? | **OVER 18 YEARS OLD ONLY**  Do you drink alcohol: 🞏 Yes 🞏 No  **If yes**, please answer the following questions:  How many units do you have on a typical day that contain alcohol?  🞏 **1 unit** = Half pint of beer or cider **(4%)**,  A single measure of spirit **(40%)**  🞏 **2 unit** = A standard glass of wine or champagne  🞏 **3 unit** = A large glass of wine  🞏 **4** **unit** = A large higher strength can of beer or  cider **(500ml)**  🞏 **5** 🞏**6** 🞏**7** 🞏**8** 🞏**9** 🞏**10** 🞏**11** 🞏**12+ or more** |

**Female patients only ……**

**vej**

Are you currently, or think you may be 🞏 Yes 🞏 No

pregnant?

If yes, have already been booked for antinatel care localy 🞏 Yes 🞏 No

**Next of kin\* ……**

**vej**

Title: Gender: 🞏 Male 🞏 Female

Full name:

Tel. contact number: Relationship:

**Data sharing consent choices\*..…**

**vej**

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). For further information please request the 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 request and complete the form from reception.

We use text and email to contact patients if you **do not** wish us to contact you in this way please contact reception 10 days after sending this form.

**Patient Rights and Responsibility & Signature**

**vej**

|  |
| --- |
| **Patient rights and responsibilities**  We aim to treat our patients courteously at all times and expect our patients to treats our staff in a similarly respectful way. The practice fully upholds the NHS zero tolerance policy and will not accept abusive, threatening or violent behaviour from our patients, their relatives, carers or representatives towards members of our staff. Should this occur we reserve the right to have you removed from our list. It is your responsibility to keep your appointments, inform us of your past illnesses, medication, hospital admissions and any other relevant details. |

**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\* 🞏