UPPERTHORPE MEDICAL CENTRE

Please complete this form and also a GMS1 form (Purple form) fully and hand into reception.

Please bring proof of address in with the completed forms, and passport if you have not had a doctor in the UK before.

We ask for 1 week in order to get you registered on the system before you can make any appointments.

For Office use only

- ○ Form fully completed& GMS1
- ○ ID Verified and photocopied
- ○ Proof address seen
- ○ Summary Care Record completed

Signed _____

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 ☐☐☐☐☐☐☐☐☐☐(if known)

Occupation

Town & country of Birth

Address

Post Code:

Telephone number: e number:

Email address:

SMS Appointment Messaging& other health related communications

If you wish to receive SMS communication from the surgery, please tick the following box ☐

Do You Have Any Communication Issues Regarding Sight or Hearing

YesN☐ ☐

(NOTE - if you indicate yes a further brief questionnaire will be posted to you for completion and return)

Do You Require an Interpreter?

Yes ☐ NoIf y☐ aswered yes, which Language? ……

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

Do you have any children?

Name	Date of Birth	Name	Date of Birth

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 anyclose 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 to copy

Name of medication	Dosage

If you would like to nominate a pharmacy so your prescriptions can be sent electronically please advise us of the name and address of the chemist _____

Lifestyle ……

Please enter your height & weight:

Height:	Weight:

Lifestyle diet ……

Varied diet ☐ Vegetarian ☐

Vegan diet ☐ Other☐ (please state)

How many pieces of of fruit and vegetables do you eat per day?

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 smokedaily? ☐<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 If yes, please answer the following questions:

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

What is your spoken Language?

Next of kin ……

Name: Tel. contact number:

Relationship:

Record Sharing

Do you consent to the sharing of data recorded here with any other organisations that may care for you?

□**Yes** - share with other organisations.

□**No** – Do not share any data recorded here.

Summary Care Record patient

If you have been registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

Yes – I would like a Summary Care Record

□ Express consent for medication, allergies and adverse reactions only.You wish to share information about medication, allergies for adverse reactions only.

or

□ Express consent for medication, allergies, adverse reactions and additional information.
Additional information is your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), and what support you might need and who should be contacted for more information about you.

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record (opt out). Select this option if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

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 ☐