**CONFIDENTIAL MEDICAL REGISTRATION FORM**

**ROWNER SURGERY**

**ADULT QUESTIONNAIRE ( 15 YEAR’S AND OVER )**

**PLEASE NOTE YOUR NAMED ACCOUNTABLE GP IS DR GOHER ALTAF UNLESS YOU ARE INFORMED OTHERWISE**

**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

Town & country of Birth

Post Code:

Address

Telephone number:

Mobile number:

Email address:

Are you happy for us to contact you by telephone 🞏 Yes 🞏 No By text 🞏 Yes 🞏 No By email Yes 🞏 No

By supplying your email address we may contact you from time to time with news and surveys from the surgery.

Would you be interested to learn more about our Patient Participation Group 🞏 Yes 🞏 No

Are you a carer? 🞏 Yes 🞏 No

Do you have a carer? 🞏 Yes 🞏 No

If yes, please tell us the name,address and

contact number of your Carer:

Are you happy for us to contact your carer

and discuss your medical record when necessary ?

🞏 Yes 🞏 No

Have you ever served in the Armed Forces? 🞏 Yes 🞏 No

Is your Mother/Father/Partner/Spouse a serving member of the Armed Forces ? 🞏 Yes 🞏 No

Is your Mother/Father/Partner/Spouse a Military Veteran?

🞏 Yes 🞏 No

Do you have any special communication requirements? ie difficulty with hearing, speech or sight

🞏 Yes 🞏 No

**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 |
|  |  | 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 |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Allergies ……**

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

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |
|  |  |

**Regular medication ……**

**Please list any medication you take on a regular basis**

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

**Please make a GP appointment if you take regular medication**

**Lifestyle ……(not applicable if under 15 years of age)**

Do you smoke: 🞏 Yes 🞏 No

If yes, do you smoke: 🞏 Cigarette 🞏 Cigars 🞏 Pipe

Are you an ex-smoker? 🞏 Yes 🞏 No

When did you give up?

Would you like help to quit smoking? 🞏 Yes 🞏 No

**Alcohol Consumption**

**1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit**

Do you drink alcohol: 🞏 Yes 🞏 No If yes, please answer the following question

How many units of alcohol do you consume in a week ?

[ ] number of units

Decline to state alcohol consumption 🞏

**Female Patients only**

Have you had a cervical smear test? 🞏 Yes 🞏 No

If yes, what was the result (if known)

Date (if known) 

**Ethnicity ……**

**vej**

Please indicate your ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African

🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Decline to state

Do you need an interpreter 🞏 Yes 🞏 No

**Next of kin ……**

**vej**

Name:

Contact telephone number:

Relationship:

Are you happy for us to discuss your medical record with them if necessary : 🞏 Yes 🞏 No

**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). Please read the accompanying 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 complete and return the form found attached with this pack.

If you do not return this form to us then certain medical information will be available to other healthcare organisations.

**Online Services**

If you would like to register for online services ( making appointments and ordering repeat medication)

Please tick to confirm that you have read and understood the details provided in our practice leaflet 🞏

**Patient Contact Waiver**

In accordance with the Data Protection Act the Practice is required to have the patient’s consent in order to speak to a third party.

Are you happy for a member of your household to take a message for you? 🞏 Yes 🞏 No

Are you happy for a message to be left on your answerphone asking you to contact Rowner Surgery? 🞏 Yes 🞏 No

**Signature ……**

**vej**

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 🞏