BLACKTHORN HEALTH CENTRE – MEDICAL REGISTRATION (OVER 16)

Please complete all pages in FULL using BLOCK capitals

Surname:

First Name(s): (in full)

Date of Birth: (day/month/year)

NHS Number: (if known)

Telephone Number:

Mobile Number:

Email Address:

Lifestyle:

Height:	**Weight**:	**Blood Pressure**:

About Yourself:

Are you a carer?
(if you are a carer by profession and are not a carer for someone outside of work, then please tick the 'No' box)

Yes No

If yes, please tell us the name and address of the person(s) you are a Carer for:

Do you have a carer? Yes No

If yes, please tell us the name and address of your Carer:

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

Are you Housebound?
(eg. you are physically unable to leave your home)

Yes No

Occupation:

Personal Medical History / Disabilities:

Do you have any disabilities or have you ever suffered from any important medical illness, operation or admission to hospital that you wish to inform us of?
If so please enter the details below:

Condition	Year Diagnosed	Ongoing
		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?

Immunisations:

Immunsation	Year	Immunisation	Year
Tetanus		Yellow Fever	
Typhoid		Other	
Polio			

Current Medication:

If you have a copy of your repeat medications, please pass to Reception to copy.
Please note, you may need to see a Doctor before your prescription(s) are isued.

Name of Medication	Strength	Dosage

Do you have a prefered Pharmacy / Chemist you would like your medication to electronically go to?

Yes

No

(if yes, which Pharmacy / Chemist do you use?)

Lifestyle – Smoking:

Do you Smoke? Yes No

If yes, what do you Smoke? Cigarette Roll own Cigarette eCigarette Cigar Pipe

How much do you smoke daily? <1 1 to 9 10 to19 20 to 39 40+

If you smoke a pipe or roll your own cigarettes, how many grames do you smoke a week?

Would you like help to quit smoking? Yes No If you wish to stop Smoking you can contact Quit4Life on 0845 602 4663 or you can visit www.quit4life.nhs.uk for more information.

Are you an ex-smoker? Yes No

If yes, when did you give up?

Lifestyle – Alcohol:

Do you drink Alcohol? Yes No Never ***If yes, please answer the following questions***:

How often do you have a drink that contains Alcohol?	Never	Monthly or Less	2 to 4 times per month	2 to 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 to 2	3 to 4	5 to 6	7 to 9	10+

Standard Glass of Wine = 3 units
Standard Pint of Beer / Cider = 3 units
1 measure of Spirit = 1 unit

How often do you have 6 or more standard drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost Daily

Next of Kin:

Name: ____ **Telephone Number**: ____

Relationship: ____

In the event of an Emergency can we contact your Next of Kin? Yes No

Ethnicity:

Please indicate your ethnic origin:

British or mixed British | Irish | African | Caribbean | Indian | Pakistani

Bangladeshi | Chinese | Other (please state): ____

Decline to State

Communication Preferences:

Where you have provided information on how to contact you, can you confirm you are happy for Blackthorn Health Centre to contact you by the following:

By E-Mail	Yes	No	This will be to send you letters, newsletter, recalls, patient surveys and practice communications
By SMS Text Message	Yes	No	This will NOT opt you out of appointment reminders sent via SMS text messages

Accessible Information:

Do you have any Information or Communication needs, (such as Hearing Aids) or are you Deaf or Blind?

If yes, please provide as much details as possible:

Do you require an alternative correspondence format?

No Yes, Braille Yes, Large Print Yes, Audio Tape

What is your preferred communication method?

No Preference Telephone SMS Message E-Mail Address

Letter to Home Address

Correspondence to Another Address (Carer or Relative)

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