

Please complete BOTH SIDES in FULL using BLACK and BLOCK CAPITALS

Have you registered at this practice before? Yes No

NHS Number (if known)

Title
 Mr / Miss / Mrs / Dr / Prof / Other.....

Surname or family name

First name

Other forenames – Please give all remaining forenames

Previous surname (if married or have been known by another surname previously)
 ONLY IF APPLICABLE

Date of birth (Day/Month/Year)
 / /

Gender
 Male Female

Southampton address

Post code

Mobile telephone (including full code)

May we use a text service to contact you in future? Yes No

Home telephone (including area code)

Email

May we use email to contact you in future? Yes No

University department

Date of expected departure from university/end of course (month/year)

Ethnic origin

Next of kin
 Name:
 Telephone:
 If considered necessary by a healthcare professional, may we contact your next of kin? Yes No

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). Do you give your permission for us to upload data to:
 Hampshire Health Record Yes No
 Summary Care Record Yes No
 Care.Data Yes No

WOMEN ONLY
 Have you ever had a cervical smear test?
 No When:
 Yes Where:
 Results: Normal / Abnormal
 Please give details: Next smear due date:

Please tick if you currently or have ever suffered any of the following problems: Date diagnosed

Asthma (only if using inhalers in the last year)		
Diabetes (with or without insulin)		
Epilepsy		
Rheumatoid Arthritis or Osteoporosis		
Raised blood pressure		
Ischaemic heart disease/coronary heart disease		
Angina (heart, <i>NOT</i> throat related)		
Heart attack (myocardial infarction)		
Heart failure		
Atrial fibrillation (AF)		
Chronic kidney disease		
Schizophrenia		
Bipolar disorder		
Other psychotic illness		
Dementia (e.g. Alzheimer's disease)		
Stroke or mini-strokes (TIA's)		
Cancer		
Emphysema/Chronic bronchitis/COPD		

Do you smoke?
 Never smoked Currently smoke
 Previously smoked → How many _____ per day

What is your height & weight?
 Weight kgs / st/lbs Height cms / ft/in

What is your average alcohol consumption?
 1 unit = ½ pint beer, lager or cider / 1 single measure spirit / 1 glass (125ml) wine
 units/wk

Are you allergic to any medications?
 No / Yes ⇒ Please state the drug and the reaction suffered, with a date if known

Are you taking any medication currently?
 No / Yes ⇒ Please include contraception, creams or other items obtained on prescription

Do you have any other medical problems not listed above or have you ever been seen in a hospital or other clinic?
 No / Yes ⇒ Please give details of what for, who and when

Have you ever had the following vaccinations?

	Yes	Date given:	No	Would you like to receive this immunisation?
Meningitis C	<input type="checkbox"/> ⇒	Date:	<input type="checkbox"/> ⇒	Yes <input type="checkbox"/> No <input type="checkbox"/>
MMR or rubella	<input type="checkbox"/> ⇒	#1: Booster:	<input type="checkbox"/> ⇒	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tetanus	<input type="checkbox"/> ⇒	Last:	<input type="checkbox"/> ⇒	Yes <input type="checkbox"/> No <input type="checkbox"/>

PRACTICE USE SCANNED []

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FAMILY DOCTOR SERVICES REGISTRATION

The following information is required by the Health Authority to complete your registration.

Surname	
Forenames (in full please)	
Date of birth (Day/Month/Year)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Your NHS number (if known)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Your previous surname (if applicable)	
Town & country of birth	

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

Your previous address in the UK (e.g. home or parental address) PLEASE INCLUDE THE POSTCODE	
Name of previous doctor while at that address	Dr.
Address of previous doctor	

If you are from abroad

Your first UK address where registered with a GP	
If previously resident in the UK, date of leaving	
Date you first came to live in the UK	

If you are returning from the Armed Forces

Address before enlisting	
Enlistment date:	Service/personnel number:

Carer status

Are you the carer for someone with a disability or physical or mental care need? No Yes: Who?

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate:

Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body
Signature confirming consent to organ donation: _____ Date: _____

If you are registering a child under 5

I wish the child named overleaf to be registered with the University Health Service for Child Health Surveillance

Please tick:

Signature of patient
 Signature on behalf of the patient

Signature: _____

Date: (day/month/year)

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