UNIVERSITY HEALTH SERVICE CONFIDENTIAL MEDICAL REGISTRATION FORM HIGHFIELD HEALTH

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 ☐

Yes ☐
Please give details:

When:
Where:
Results: Normal / Abnormal
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, *NOT* 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 ACWY	☐⇨	Date:	☐⇨	Yes ☐ No ☐
MMR or rubella	☐⇨	#1: Booster:	☐⇨	Yes ☐ No ☐
Tetanus	☐⇨	Last:	☐⇨	Yes ☐ No ☐

PRACTICE USE SCANNED [ ] NAMED GP GIVEN [ ]

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UNIVERSITY HEALTH SERVICE **CONFIDENTIAL MEDICAL REGISTRATION FORM** **HIGHFIELD HEALTH**

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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)	☐☐ / ☐☐ / ☐☐☐☐
Your NHS number (if known)	☐☐☐ ☐☐☐ ☐☐☐☐
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?

Signature

Please tick: **Signature:** **Date:** (day/month/year)

☐ Signature of patient
☐ Signature on behalf of the patient

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:

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