NHS **GMS1 MEDICAL REGISTRATION FORM** April 2011

FOR OFFICE USE ONLY

Please complete in **BLOCK CAPITALS** and tick ☑ as appropriate

1. Have you ever registered with us before? ☐ Yes ☐ No

2. Sex ☐ Male ☐ Female

3. **Mr** ☐ **Miss** ☐ **Mrs** ☐ **Ms** ☐ **Other** ....

4. Family name (last name)**:**

5. First name:

6. YOUR SIGNATURE: **Date:**

7. Date of birth: d: m: y:

8. NHS number (If known)**:**

9. Reading address:

10. Postcode:

11. Mobile telephone:

12. Landline telephone:

13. Email:

We will use your mobile telephone number to SMS (text) you to confirm we have registered you, and in future to send you automatic appointment reminder texts before any booked appointments and for occasional invitations to health screening events. We will NOT use it for marketing etc. Inform Reception if you do not want us to use your mobile telephone number for these SMS messages.

Help us to trace your previous medical records by providing the following info:

UNITED KINGDOM ORIGIN –

14. Home address (details before you came to Reading)**:**

15. Postcode:

16. Town of birth:

17. Name of your current doctor or medical practice:

INTERNATIONAL ORIGIN –

Details before you came to Reading

14. Country of birth:

15. Date of entry into the UK: d______m______ y______

If you have ever registered with a doctor in the UK you must answer questions 16-17

16. Name of most recent doctor or name of medical practice in the UK:

17. The address you were living in when you were registered with that doctor:

19. Ethnicity:

White:
- ☐ British
- ☐ Irish
- ☐ Other

Mixed:
- ☐ White / black African
- ☐ White / black Caribbean
- ☐ White / Asian
- ☐ Other background

Asian or Asian British:
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Other Asian

Black or Black British:
- ☐ Caribbean
- ☐ African
- ☐ Other background

Other Ethnic Group:
- ☐ Chinese
- ☐ Any other ethnic group

- ☐ I do not wish to give this information

20. First language: ☐ English ☐ Other – specify:

21. Country of origin:

STRICTLY CONFIDENTIAL TO THE UNIVERSITY OF READING MEDICAL PRACTICE

Please fill this form accurately, as the information which you provide becomes part of your medical record

1. Family name (last name)		**2. First name**	
3. Date	d m y	**4. Are you a carer?**	

5. Height		**6. Weight**	kg
7. Do you smoke?	☐ Yes ☐ Stopped ☐ Never	**If yes, how many per day?**	
8. Have you been immunised against Meningitis C	☐ Yes Year………………. ☐ No		
9. Have you had TWO immunisations of MMR (protection against Measles Mumps and Rubella)	☐ Yes Year of 1st dose………………. ☐ No Year of 2nd dose……………….		

10. Female patients – Cervical smear information (Papanicolaou test)

☐ Never had a cervical smear **Last smear was:** m______ y_________ **Result:** ☐ Normal ☐ Abnormal

11. Allergies or Reactions – Give details if you have had an allergic reaction to: eggs, medicine, vaccinations, food

12. Medical History

Do you have any of the following conditions and if so please give the date of diagnosis:

High Blood Pressure ☐ ……/……/…… Anxiety ☐ ……/……/…… Asthma ☐ ……/……/……

Epilepsy ☐ ……/……/…… Stroke/TIA ☐ ……/……/…… Depression ☐ ……/……/……

Thyroid disease ☐ ……/……/…… Diabetes ☐ ……/……/……

Mental health condition ☐ Please specify…………………………………………… ……/……/……

Heart disease ☐ Please specify…………………………………………… ……/……/……

Operations ☐ Please specify…………………………………………… ……/……/……

Other ☐ Please specify…………………………………………… ……/……/……

Condition(s)	Please list any other serious or ongoing illnesses or operations that you have had.

Please list any recurrent medication that you take (including contraception and inhalers or enter 'NONE')

13. Medication	Form (e.g. tablets, spray)	Strength	How many & times per day	RD	RP

14. Do you have any specific needs? – Please give details below