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 of birth	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