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

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:

Alcohol Questionnaire

Please provide as much information as possible. This will improve the care we provide for you.

University of Reading
Medical Practice

Name:
Date of birth:
Today's date:

GUIDE TO ALCOHOL UNITS

Pint of beer/lager/cider = 2 units

Alcopop or can of beer = 1.5 units

Glass of wine (175mls) = 2 units

Single measure of spirits = 1 unit

Bottle of wine = 9 units

We know that one in four adults in the UK are drinking harmful levels. Taking a few moments to complete this form will help you to consider whether you might benefit from changing the way you drink.

Score each question 0,1,2,3 or 4 and add up your total at the end.

Audit C	**Questions**	**0**	**Scoring 1**	**System 2**	**3**	**4**	**Your Score**	
	How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2-3 times per week	4+ times per week		
	How many units of alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 – 4	5 – 6	7 – 8	10+		
	How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
						Total		**Box 1**

If your total is 5 or more please complete the following questions:

Audit	**Questions**	**0**	**Scoring 1**	**System 2**	**3**	**4**	**Your score**	
	How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
	How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
	How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily		
	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year		
	Has a relative/friend/ doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year		
						Total		
						Overall score		**Box 2**

Appointments online Request form

This service allows you to book and cancel appointments via the web.

Please complete details below and sign to confirm your request to take part in this initiative.

Confirmation of acceptance with brief operating guidelines, Username and password will be sent to your registered address.

Name:

Telephone Number:

Mobile Number:

Date of Birth:

Signature:

Free text message appointment reminders

If you do NOT wish to receive text message appointment reminders please tick box. ☐

If you have not received your password in 4 – 6 weeks please contact the University Health Centre.

Thank you