Do you have any special communication needs?
☐ Yes ☐ No If yes: ☐ Sign Language ☐
Large Print ☐ Other .....

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames
Title ☐Mr ☐Mrs☐Miss☐Ms

Sex ☐ Male ☐ Female Date of Birth (day/ month/year)

NHS Number

Town & country of Birth Address

LARGE PRINT CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Post Code:

Telephone number Mobile number:

Email address:

Your previous address in UK

Name of previous Doctor while at that address

Address of previous Doctor

Your first UK address where Registered with a GP

If previously resident in UK date of leaving

Date you first came to UK

If you are from abroad:

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

Post Code:

Post Code:

Post Code:

I

NHS Organ Donor registration:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.
For more information please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk or call 0300 123 23 23

NHS Blood Donor registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)

..... Post code: .....

Personal Medical History.....

Type of Birth:

(eg normal, forceps, CaesareanIf under 5)

Birth Weight:

(If under 5)

Feeding:

(Breast or bottlefed if under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family History.....

Have any close relatives (father, mother, sister, brother only) ever suffered from: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations .....

Please provide details of your childs immunisations with dates if possible (under 5's). If

possible please give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles		BCG (TB)	
MMR		Meningitis	

List of current medication .....

If you have a copy of your repeat medications, please pass to Reception

to copy

Name of medication	Dosage

Allergies .....

Please list any allergies you have to any drugs/ medication:

Name of medication

What was the problem or upset?

Ethnicity .....

vej

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ Other (please state):
☐ Decline to state

Next of kin .....

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Name:
Tel. contact number: Relationship:

Where you have provided information on how to contact you, can you confirm you are happy for Brondesbury Medical Centre to contact you by the following:

Bytext ☐Yes ☐No Thiswillbetosendyoureminders of appointments via text

Signature .....

vej

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient ☐ Signature of patient ☐