OLMC

**Office Use only**

NPHC date….…………

Time……………………

Old Leake Medical Centre

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| Title: Mr/Mrs/Ms/Miss/Dr: |
| Full Name: |
| Previous Surname(s): |
| Date of Birth: |
| NHS Number : |
| Town & Country of Birth: |
| Ethnicity: First language: |
| Current Address & Postcode: |
| Home Telephone Number:  Mobile Telephone Number:  Work Telephone Number:  Do you consent to OLMC sending appointment reminders and one off messages to you via text? Yes/No |
| Other Members of your Household: |
| Previous Address & Postcode: (If you are returning from abroad, please give last UK address) |
| Name & Address of Previous Doctor:  (If you are returning from abroad, please give last doctor you were registered with in the UK) |
| Do you consent to OLMC creating a Summary Care Record for you?  Yes/No |
| **If you were born outside of the UK:**  When you first registered with a Doctor in the UK, what was your first UK address?  What date did you first come to live in the UK?  If you were previously a resident in the UK, what date did you leave? |
| **If you are returning from the armed forces:**  What was your address before enlisting?  What was your service or personnel number?  What date did you enlist? What date did leave the forces?  What date did you leave? |
| I confirm that the information contained in this Registration form is accurate  Signed………………………………………………………………………… date ……………………. |
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| **MEDICAL INFORMATION Very important - Please Complete.**  Past & Present Illnesses, Operations and any other conditions you are receiving treatment/medication for:  Allergies:  Medication: Name Strength Dose |
| **HEALTH INFORMATION**  **Do any of your family members have any of the following?**   * Heart disease? Yes/No Who? * Raised blood pressure? Yes/No Who? * Diabetes? Yes/No Who? * Asthma or Hay Fever? Yes/No Who? * Eczema? Yes/No Who? * Glaucoma? Yes/No Who? * Stroke? Yes/No Who? |
| **Occupation:** |
| **Smoking History:**  Do you smoke? Yes/No If so, how many?  If you were previously a smoker what did you smoke, how many and when did you quit? |
| **Alcohol:**  How many units do you drink per week? |
| **What is your:**   * Height? • Weight? |
| Are you up-to-date with your immunisations?Yes/No |
| **For women only**  When was your last cervical smear? Result (if known):  How many pregnancies have you had?  What contraception are you using? |