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 accurateSigned………………………………………………………………………… 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? |