THE SHRUBBERIES MEDICAL CENTRE

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other …….

LARGE PRINT
CONFIDENTIAL MEDICAL REGISTRATION FORM
(CHILDREN UNDER 16)

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If 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 pelase 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

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 ……

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 ……

Name: _____

Tel. contact number: _____

Relationship: _____

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email	☐ Yes	☐ No	This will be to send you letters, newsletter and the like
By text	☐ Yes	☐ No	This will be to send you reminders of appointments via text

Signature ……

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 ☐

22/07/16