Poole Medical Centre Surgery: EMIS No:

CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number (if known) ☐☐☐ ☐☐☐ ☐☐☐☐

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

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

Your previous address in UK

Post Code:

Name of previous Doctor while at that address

Address of previous Doctor

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

If registering a child under 5:

☐ I wish the child above to be registered with Poole Medical Centre for Child Health Surveillance

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

☐ I live more than 1 mile in a straight line from the nearest chemist

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			
MMR			
BCG (TB)			
Meningitis			

List of current medication ……

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

Allergies ……

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

Name of medication	What was the problem or upset?

Ethnicity ……

☐ 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 Poole Medical Centre 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 ☐

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

If yes: ☐ Sign Language ☐ Large Print ☐ Other

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