SELHURST MEDICAL CENTRE

ADULT REGISTRATION FORM

PERSONAL HISTORY	
FIRST NAME:	
SURNAME:	
PREVIOUS SURNAME:	
DATE OF BIRTH :	
GENDER:	MALE / FEMALE
ADDRESS:	
PLACE OF BIRTH	
NATIONALITY	
MAIN SPOKEN LANGUAGE	Interpreter Required? YES / NO
OCCUPATION	
CONTACT NUMBER	HOME: MOBILE:
EMAIL:	
NEXT OF KIN:	NAME:
	RELATIONSHIP:

	NOK REGISTERED AT SELHURST MEDICAL CENTRE? YES /NO
	ADDRESS:
	CONTACT NO:
	CAN DISCUSS RECORD: YES /NO

MEDICAL AND FAMILY HISTORY	
Any present illnesses? If yes, please state	
Any regular medication? If yes, please list here	
Are you housebound: Yes / No	
Any known allergies – medicine	
Are you a carer?	Yes No

Have you or other family members suffered from the following: **Please tick**

	You	Other family member
Heart problems		(inc age at diagnosis)
Stroke		
High blood pressure		
Diabetes		
Glaucoma		
Cancer		
Epilepsy		
Asthma		

Date & Result of last SMEAR ***WOMEN ONLY***	

Hearing Impairment	
Visual Impairment	
Speech Impairment	
Physical Disability (e.g. wheelchair)	
Learning Disability	
Other (please specify)	

Please let the practice know if you would like communication in a specific format i.e large print

LIFESTYLE	
Do you smoke?	YES/ NO
If yes, how many per week?	
If you are an ex-smoker, how long did you smoke for?	
What type of smoker were you? (please circle)	Light Moderate Heavy
Your current	Height …….Weight ……
How much exercise do you do regularly?	Light Moderate Heavy
Do you eat a varied diet? Including milk, meat, vegetables and fruit	YES/ NO

ETHNICITY

White-British ☐ Mixed-Asian/White ☐ Indian ☐

White-Irish ☐	Mixed-any other ☐	Pakistani ☐
White-other White ☐	Black African ☐	Bangladeshi ☐
Mixed-Black Caribbean/White ☐	Black-Caribbean ☐	Asian-other ☐
Mixed-Black African/White ☐	Black-other ☐	Chinese ☐
Any other ethnic group ☐		

Important Notes:

If you are going to require repeat medication immediately after registration without seeing a doctor, please obtain full details from your previous GP and pass it to the receptionist with your written repeat prescription request. We will be unable to issue repeat prescriptions without an appointment with a doctor if this information is not provided.

Text Messages

If you wish to receive text messages, please read the disclaimer below then complete and sign the slip below. Return it to the surgery.

a) I consent to Selhurst Medical Cente Contacting me by text message for the purposes of health promotion, results (in the future) and for appointment reminders.

b) I acknowledge that appointment reminders by text are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

Text messages are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual to be identified.

☐ I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

☐ I don't not wish to receive information by text message

Patients Agreement

We ask all patients to **AGREE NOT TO BE ABUSIVE TO OUR STAFF**,

THE SURGERY HAS A ZERO TOLERANCE POLICY

Name…….. Date of birth…….

Mobile Number…….

Signed…… Date…….

For office use only: Date rec'd……. Date actioned …….. ….
Initials……..