STUDENT PAPER REG FORM

DE MONTFORT SURGERY STUDENT PATIENT REGISTRATION FORM

Male/Female

Title: Mr/Mrs/Miss/Ms/Dr/Other…..

Student/Non Student/DMU Staff

Surname:

First Names:

Previous Surname:

Date of Birth:

Town and Country of Birth:

Mobile ………………………

Home………………………..

Email

….…………………………………

Leicester Address:-
Room Number:
Flat Number:
Hall:
Road:
Post Code:

Previous address:

GP whilst at previous address:

If you have recently moved to the UK please state date of entry: ……………

Name and telephone number of next of kin:

What is your ethnicity?

First Language?

NHS Number (If Known):-

NHS blood/organ donor registration
I would like to join the NHS organ donor register as someone whose organs may be used for transplantation after my death (Please Circle)

Kidneys Heart Liver Corneas Lungs Pancreas Any Body Part

Signature confirming consent to organ donation………………………

I would like to join the NHS blood donor register as someone who may be contacted to donate blood. **Yes** or **no** (please circle.)

Have you donated blood in the last 3 years? **Yes** or **No** (Please circle)

Do you suffer from any existing medical conditions?

Have you had any previous mental health problems?

Are you on any current medication?

Significant Past Medical History:

Family Medical History (please state family member and condition.)

Any known allergies (please specify)

Alcohol Audit:

1. **How often do you have a drink that contains alcohol?**

N/A ☐ **Never (0)** ☐ **Monthly or less(1)** ☐ **2-4 times per month(2)** ☐

2-3 times per week(3) ☐ **4+ times per week (4)** ☐

2. **How many standard alcoholic drinks do you have on a typical day when you are drinking?**

N/A ☐ **1-2(0)** ☐ **3-4(1)** ☐ **5-6(2)** ☐ **7-9(3)** ☐ **10+(4)** ☐

3. **How often do you have 6 or more standard drinks on one occasion?**

N/A ☐ **Never(0)** ☐ **Less than monthly(1)** ☐ **Monthly(2)** ☐ **Weekly(3)** ☐

Daily or almost daily(4) ☐

Alcohol Screen – Audit C completed ☐

Do you smoke? Current Smoker/ex-smoker/never smoked **(Please Circle)**
How many do you smoke per day? …………

Do you exercise? None/Some/more than 3 times a week **(Please circle)**

Please provide your Height and weight in the spaces provided.

Height……………………

Weight…………………..

Are you fully vaccinated?

Yes or No (Please Circle)
If unsure please book an appointment to discuss with the practice nurse.

Are you a carer?

Do you have a carer?

Please give any further relevant information:

YOU CAN NOW BOOK APPOINTMENTS AND REQUEST REPEAT PRESCRIPTIONS ON OUR WEBSITE, PLEASE ASK AT RECEPTION FOR USERNAME AND PASSWORD FOR THIS FACILITY.

If you have answered Yes to any of the conditions in the Current Medical Information section or are aged 40 or over, please contact the Health Centre to make an appointment for a New Patient Check.
If on repeat medication (except contraception) please make an appointment with the doctor. For contraception please make an appointment with the nurse.

Please read the patient information leaflet about your Summary Care Record (SCR). If you wish to opt out please tick the box. (information also available on our website www.DeMontfortSurgery.co.uk) ☐

Please note that it is your responsibility to ensure your contact details are correct and you acknowledge this by signing this application form to register with De Montfort Surgery.
By giving us your mobile number you are agreeing to the surgery contacting you via text message.

Signature: …………………………………….. **Date: …………………………………..**