BARONSCOURT SURGERY MEDICAL HISTORY FORM

To allow us to process your registration efficiently, please complete all sections of the attached forms and return to us with the following identification:

1. Proof of Identification – e.g. Passport, Driving Licence or Birth Certificate
2. Proof of Address – e.g. Utility Bill, Council Tax Letter or Rent Letter

(If you do not have the above, please speak to a receptionist)

Please list below details of any people in your family currently registered at this surgery.

Full Name	Date of Birth	Relationship	Address

Are you on any current medication?

Name	Dose	Instructions	Illness

Have you previously been registered at Baronscourt Surgery? Yes ☐ No ☐

Do you care for someone with a disability? Yes ☐ No ☐

Do you have a carer? Yes ☐ No ☐

Do you give consent to share information with Out of Hours, Local hospitals and other Emergency Health Services for your Clinical Need? (KIS Key Information Summary) Yes ☐ No ☐
https://baronscourtsurgery.co.uk/info.aspx?p=3&pr=S70658&t=1&high=kis

Do you give consent for SMS text communication? Yes ☐ No ☐
(SMS for messages related to your medical care, including appointment reminders and messages about results)

****Consent for KIS and SMS can be withdrawn at any time by contacting the Surgery****

OFFICE USE ONLY	SMS Accept #9NdP	SMS Decline #9NdQ
	KIS Consent #9Ndr	KIS Decline #9Nds

Ethnic Origin

White British ☐ White Irish ☐ White Asian ☐ Black Asian☐ Chinese ☐
Indian ☐ Pakistani ☐ Black African ☐ White and Black African ☐

Black Caribbean ☐ Other _____
First Name _____ Surname _____

Date of Birth _____ Marital Status _____

Address_____

_____ Post Code _____

Telephone No. _____ Mobile No._____

If you were born outside the UK, when did you first arrive in the UK? _____
If you were born in the UK but have been living abroad, when did you leave and return to the UK?
Date you left _____ Date you returned _____

Will you require a translator at your appointments? Language_____

Emergency Contact/Next of Kin

First Name _____ Surname _____

Relationship to you _____ Contact Number _____

Address_____

_____ Post Code _____

Medical History

Allergies _____

Details of Illnesses, Operations, Chronic Diseases, Accidents or Pregnancies

_____

_____

_____

Height _____ Weight _____

Are you a smoker? Yes ☐ No ☐

If yes, how many do you smoke a day? _____

Have you ever smoked? Yes ☐ No ☐

How many units of alcohol do you drink per week? _____
(A unit of alcohol if equivalent to 1 glass of wine, 1 measure of spirits or ½ beer)

Please note: It takes 48 hours to process your registration.

If you would like a new patient consultation, please book an appointment with our Phlebotomist or Nurse within 6 months of registering.