

**BRADFORD STUDENT HEALTH SERVICE GMS1 MEDICAL REGISTRATION**

**Please complete in CAPITAL LETTERS and tick  where relevant**

NHS number:		Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	
First names:			
Family name (surname):			
Date of birth: _____Day _____Month _____Year		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Birthplace (Town for UK, Country for International):			
Mobile telephone number:			
E-mail:			
Ethnic Group:	<input type="checkbox"/> White	<input type="checkbox"/> Indian	<input type="checkbox"/> Chinese
	<input type="checkbox"/> Asian	<input type="checkbox"/> Mixed	<input type="checkbox"/> Other
International students/families: If this is the first time you are registering with a doctor please complete the dates on the right:		Date you first came to live in UK:	
		Date you expect to leave the UK:	
To help us find your previous medical records please provide the following information			
Your previous address in the UK:		Name of doctor while at that address:	
		Address of previous doctor:	
Bradford address (room / flat / house number):			
Halls / Street name:			
Postcode: BD		House telephone: 01274	
Signature of patient:			Date:
Organ donor registration (optional). <input type="checkbox"/> I would like to join the NHS organ donor register as someone whose organs may be used for transplantation after my death. Tick as appropriate: <input type="checkbox"/> Kidneys <input type="checkbox"/> Heart <input type="checkbox"/> Liver <input type="checkbox"/> Corneas <input type="checkbox"/> Pancreas <input type="checkbox"/> Any part of my body			
Signature confirming consent to donation:			Date:

Place of study: <input type="checkbox"/> University <input type="checkbox"/> College
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**HEALTH QUESTIONNAIRE**

**Please tick  which most applies to your current lifestyle**

1. SMOKING: <input type="checkbox"/> Smoker <input type="checkbox"/> Ex-smoker <input type="checkbox"/> Never smoked If you smoke do you want to stop? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. ALCOHOL: In an average week how many units do you drink? (1 unit = ½ pint of beer, or 1 small glass of wine, or 1 measure of spirits). Approximate units per week: _____
3. EXERCISE: How often do you exercise? <input type="checkbox"/> less than 5 thirty minute sessions per week <input type="checkbox"/> more than 5 thirty minute sessions per week
4. ALLERGIES: Details of allergic reactions to any medicines/drugs, medical dressings, vaccines, eggs, etc: _____ Or tick <input type="checkbox"/> if no known allergies
5. FAMILY HISTORY: Are there any illnesses which tend to occur in your family? Specifically coronary heart disease or stroke? If so please specify:
6. WOMEN ONLY: Have you ever had a cervical smear test? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, date: ____/____/____ Result: <input type="checkbox"/> Negative <input type="checkbox"/> Other – specify _____
7. HEIGHT: _____cms    WEIGHT: _____kgs
8. For official use only: <ul style="list-style-type: none"> <li>1. <input type="checkbox"/> Contraceptive advice given</li> <li>2. <input type="checkbox"/> Sexual health advice given</li> <li>3. <input type="checkbox"/> Chlamydia screening offered</li> <li>4. <input type="checkbox"/> Smoking advice given</li> </ul>