**Appendix 2 – Adult Medical Summary form**

**STRICTLY CONFIDENTIAL TO THE UNIVERSITY MEDICAL GROUP**

**ADULT MEDICAL SUMMARY FORM**

Please fill this form accurately, as the information which you provide becomes part of your medical record

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| **1. Family name** (last name) |  | **2. First name** |  |
| **3. Date of birth** | d m y  | **4. Are you a carer?** |  |

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| **5. Ethnicity**Please specify the ethnic group you consider you belong to: |
| ☐White British ☐White Irish ☐ Black Caribbean ☐Black African ☐Black Caribbean and White ☐Black African and White ☐Indian ☐Pakistani ☐ Bangladeshi ☐Other ethnic group ☐I do not wish to state |

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| **6. Emergency Contact** |
| **Full name** |  | **Phone Number** |  |
| **Relationship to you** |  | **Are they your next of kin?** | ☐ Yes ☐ No  |

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| --- | --- |
| **7. Are you a student at the University of Reading?****Are you an overseas student at the University of Reading?** | ☐ Yes ☐ No ☐ Yes ☐ No If overseas student, please state course end date (month and year) ………………………… |

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| --- | --- | --- | --- |
| **8. Height** |  | **9. Weight** | kg |
| **10. Do you smoke?** | ☐ Yes ☐ Stopped ☐ Never | **If yes, how many per day?** |  |
| **11. Have you been immunised against Meningitis C** | ☐ Yes ☐ No Year ……………  |
| **12. Have you had TWO immunisations of MMR**(protection against Measles Mumps and Rubella) | ☐ Yes Year of 1st dose …………… ☐ No Year of 2nd dose …………… |
| **13. Have you or members of your household been subject to a safeguarding plan?** | ☐ Yes ☐ No  |
| **14. Have you lived abroad in the last 5 years, if so where?** | ☐ Yes ☐ No Where? …………  |

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| **15. Female patients –** Cervical smear information (Papanicolaou test) |
| ☐ Never had a cervical smear **Last smear was** m …… y …….**Result:** ☐Normal ☐ Abnormal |

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| **16. Allergies or Reactions –** Give details if you have had an allergic reaction to: eggs, medicine, vaccinations, food |
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| **17. Medical history** |
| **Do you have any of the following conditions and if so please give the date of diagnosis:**High Blood Pressure ☐ ……/……/…… Anxiety ☐ ……/……/…… Asthma ☐ ……/……/……Epilepsy ☐ ……/……/…… Stroke/TIA ☐ ……/……/…… Depression ☐ ……/……/……Thyroid disease ☐ ……/……/…… Diabetes ☐ ……/……/……Mental health condition ☐ Please specify ……………………………………………………… ……/……/……Heart disease ☐ Please specify ……………………………………………………… ……/……/……Operations ☐ Please specify ……………………………………………………… ……/……/……Other ☐ Please specify ……………………………………………………… ……/……/…… |

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| **Condition(s)** | Please list any other serious or ongoing illnesses or operations that you have had.  |
|  |  |

**Please list any recurrent medication that you take** (including contraception and inhalers or enter ‘NONE’)

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| --- | --- | --- | --- | --- | --- |
| **18. Medication** | Form(e.g. tablets.spray) | Strength | How many & times per day | RD | RP |
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| **19. Do you have any specific needs? – Please give details below** |
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