

## 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

<b>1. Family name</b> (last name)		<b>2. First name</b>	
<b>3. Date of birth</b>	d      m      y	<b>4. Are you a carer?</b>	
<b>5. Sex assigned at birth</b>		<b>6. Gender you identify as</b>	

<b>7. Ethnicity</b> Please specify the ethnic group you consider you belong to:			
<input type="checkbox"/> White British	<input type="checkbox"/> White Irish	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Black African
<input type="checkbox"/> Black Caribbean and White	<input type="checkbox"/> Black African and White	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani
<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Other ethnic group	<input type="checkbox"/> I do not wish to state	

<b>8. Emergency Contact</b>			
<b>Full name</b>		<b>Phone Number</b>	
<b>Relationship to you</b>		<b>Are they your next of kin?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>9. Are you a student at the University of Reading?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state course end date (month and year) .....
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<b>10. Are you intending to leave Reading in less than 3 years</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please state anticipated leave date: (month and year) .....
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<b>11. Height</b>		<b>10. Weight</b>	kg
<b>12. Do you smoke?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> Stopped <input type="checkbox"/> Never	<b>If yes, how many per day?</b>	
<b>13. Have you been immunised against Meningitis C</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Year .....		
<b>14. Have you had TWO immunisations of MMR</b> (protection against Measles Mumps and Rubella)	<input type="checkbox"/> Yes Year of 1 <sup>st</sup> dose ..... <input type="checkbox"/> No Year of 2 <sup>nd</sup> dose .....		
<b>15. Have you or members of your household been subject to a safeguarding plan?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>16. Have you lived abroad in the last 5 years, if so where?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No Where? .....		

<b>17. Female patients – Cervical smear information (Papanicolaou test)</b>
<input type="checkbox"/> Never had a cervical smear <b>Last smear was</b> m ..... y ..... <b>Result:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

<b>18. Allergies or Reactions – Give details if you have had an allergic reaction to: eggs, medicine, vaccinations, food</b>

**19. 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 ...../...../.....

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')**

20. Medication	Form (e.g. tablets.spray)	Strength	How many & times per day	RD	RP

**20. Do you have any specific needs? – Please give details below**

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