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

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

7. Which of the following options best describes you?	☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Other…… ☐ I prefer not to say

8. 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	☐ prefer not to say	

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

10. Are you a student at the University of Reading?	☐ Yes ☐ No If yes, please state course end date (month and year) ……

11. Whether you are student or not, are you intending to leave Reading in less than 3 years	☐ Yes ☐ No If yes, please state anticipated leave date: (month and year) ……

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

18. All patients with a Cervix – Cervical smear information (Papanicolaou test)
☐ Never had a cervical smear **Last smear was** m …… y …….**Result:** ☐ Normal ☐ Abnormal

19. Allergies or Reactions – Give details if you have had an allergic reaction to: eggs, medicine, vaccinations, food

20. 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')

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

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