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. 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	

6. Emergency Contact

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

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) ……

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? ……	

15. Female patients – Cervical smear information (Papanicolaou test)

☐ Never had a cervical smear **Last smear was** m …… y …….**Result:** ☐ Normal ☐ Abnormal

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

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 ……	……/……/……

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')

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

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