



Patient's details Please complete in BLOCK CAPITALS and tick as appropriate

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Surname
Date of birth				First Names
NHS No				Previous surnames
<input type="checkbox"/> Male		<input type="checkbox"/> Female		Town and country of birth
Home address:				
Email address:				
Postcode		Telephone number		

Please help us trace your previous medical records by providing the following information

Your previous address in the UK	Name of previous doctor while at that address
	Address of previous doctor

If you are from abroad
Your first UK address where registered with a GP

If previously resident in the UK, date of leaving	Date you first came to live in UK
If you are returning from the Armed Forces	
Address before enlisting	

Service or personnel number	Enlistment Date
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If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*	
<input type="checkbox"/> I live more than 1 mile in a straight line from the nearest chemist	*Not all doctors are authorised to dispense medicines
<input type="checkbox"/> I would have serious difficulty in getting them from a chemist	

What is your ethnic group? Please tick ONE box only.

<input type="checkbox"/> White British	<input type="checkbox"/> White other	<input type="checkbox"/> Mediterranean
<input type="checkbox"/> Middle East / North Africa	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Black African
<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Chinese
<input type="checkbox"/> Other Asian - please write details here: _____		
<input type="checkbox"/> Mixed White and Black Caribbean	<input type="checkbox"/> Mixed White and Black African	<input type="checkbox"/> Mixed White and Asian
<input type="checkbox"/> Any other ethnic group, mixed origin - please write details here: _____		
<input type="checkbox"/> Any other ethnic group - please write details here: _____		

Signature of patient Signature on behalf of patient Date

SUMMARY CARE RECORD

NHS England are introducing a new electronic record called the Summary Care Record (SCR), which will be used to support your emergency care.

Today, records are kept in all the different places where you receive care. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.

Because the Summary Care Record is an electronic record it will give healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment when you need care in an emergency or when your GP practice is closed.

If you decide to have a Summary Care Record it will contain information about any medicines you are taking, any bad reactions to medicines that you have had, and any allergies you suffer from. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed.

You can choose whether you have a Summary Care Record or not

If you DO NOT WANT to have a Summary Care Record, you must let us know by filling in and returning the opt-out form opposite.

If you leave the form blank we will assume your consent to have a Summary Care Record created for you.

For more information on the Summary Care Record, please go to <http://www.nhs.uk/carerecords> or phone the Summary Care Record Information Line on 0300 123 3020.

SUMMARY CARE RECORD OPT-OUT FORM

If you DO NOT want a Summary Care Record please fill out this form and return it to your GP practice

A. Please complete in BLOCK CAPITALS

Title Surname / Family name
Forename(s)
Address

Postcode Phone No.

Date of birth
NHS Number (if known)
Signature .

B. If you are filling out this form on behalf of a child under 16, their GP practice will consider this request.

Please ensure you fill out **their details in section A and **your** details here in section B**

Your name
Your signature

Relationship to patient
Date

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency. Your records will stay as they are now with information being shared by letter, email, fax or phone.

FOR PRACTICE USE ONLY

Express dissent for Summary Care Record dataset upload code 9Ndo applied

Actioned by: Initials Date

THE CROUCH OAK FAMILY PRACTICE

NEW PATIENT HEALTH QUESTIONNAIRE

Today's Date:	
Surname:	Date of Birth:
First name:	NHS number if known:
Address:	Home Telephone No:
	Mobile Telephone No:
Post Code:	Email address:
Next of Kin (please make sure you have their permission to give us this information)	
Full Name/Title:	Relationship:
Full Address:	Telephone No:
Online Access: We will register you for online access to book / cancel appointments and order repeat prescriptions. If you do NOT want this access please tick here: <input type="checkbox"/> You need a separate application form to request access to view your medical records online. Please ask at reception or download the application form from our web site.	

Ethnic category	Please tick	Ethnic category	Please tick
White	British <input type="checkbox"/>	Asian/Asian British	Indian <input type="checkbox"/>
	Irish <input type="checkbox"/>		Pakistani <input type="checkbox"/>
	Other White <input type="checkbox"/>		Bangladeshi <input type="checkbox"/>
Mixed	White & Black Caribbean <input type="checkbox"/>	Other Ethnic	Other Asian <input type="checkbox"/>
	White & Black African <input type="checkbox"/>		Sri Lankan <input type="checkbox"/>
	White & Asian <input type="checkbox"/>		Korean <input type="checkbox"/>
	Other Mixed <input type="checkbox"/>		Chinese <input type="checkbox"/>
Black/Black British	Black Caribbean <input type="checkbox"/>	Not Stated	Other Ethnic category <input type="checkbox"/>
	Black African <input type="checkbox"/>		Not stated <input type="checkbox"/>
	Other Black <input type="checkbox"/>		

First language if not English:

Medical history: Have you ever suffered from any of the following:

<input type="checkbox"/> Diabetes	Date:	<input type="checkbox"/> Heart Problems	Date:
<input type="checkbox"/> Epilepsy	Date:	<input type="checkbox"/> Chronic Kidney Disease	Date:
<input type="checkbox"/> Thyroid problems	Date:	<input type="checkbox"/> Stroke	Date:
<input type="checkbox"/> High Cholesterol	Date:	<input type="checkbox"/> Asthma / COPD	Date:
<input type="checkbox"/> High Blood Pressure	Date:		

Other – please give details with dates:

Operations – please give details with dates:

Medication: Please list any medication you take regularly
(Please note that if you require any medication prescribed on a repeat basis you will need to make a routine appointment for a medication review with one of our doctors before this can be arranged)

Nominated pharmacy for electronic prescriptions - please provide name and address:

(if you leave this blank we will remove any previously nominated pharmacies)

Allergies: Please list any allergies

Smoking: please tick the relevant box and complete as appropriate below

<input type="checkbox"/> I smoke _____ per day	<input type="checkbox"/> I used to smoke _____ per day.
<input type="checkbox"/> I have never smoked.	I stopped smoking _____

Alcohol: How many units of alcohol do you drink in a week? (1 unit = half a pint of beer or one glass of wine)

Family History: please tell us about the health of your family

Mother: Heart disease
 Stroke
 High Blood Pressure
 Diabetes
 Cancer
 Other:

Father: Heart disease
 Stroke
 High Blood Pressure
 Diabetes
 Cancer
 Other:

Siblings: Heart disease
 Stroke
 High Blood Pressure
 Diabetes
 Cancer
 Other:

Height / Weight

Please complete if known:

Height

Weight

Carers

Are you a carer? YES / NO

If yes please provide name and address:

Adult Immunisations

Flu Date given:
 Tetanus Date given:

Pneumonia Date given:
 Shingles Date given:

Female patients: It is very important that we have details of when you last had a cervical smear and who performed the test. If you have had a hysterectomy we need to know the date of the operation.

Date of last cervical smear: _____ Result: _____

Have you had a hysterectomy? Yes / No If Yes, please give date: _____

What contraception (if any) do you use? _____

(Please note that if you use any oral contraceptive pill you will need to make an appointment for a pill check with the practice nurse)

Children (0-6) Immunisations. We must have complete details of vaccinations and immunisations already performed. If you cannot remember dates, please give approximate dates and bring in your child's Health Record for checking.

Vaccination	Age	Date Given
BCG	Birth	
Diphtheria / Tetanus / Pertussis / Hib / Polio / Pneumococcal	2 months	
Diphtheria / Tetanus / Pertussis / Hib / Polio / Meningitis C	3 months	
Diphtheria / Tetanus / Pertussis / Hib / Polio / Meningitis C / Pneumococcal	4 months	
Hib/Meningitis C	12 months	
Measles / Mumps / Rubella/Pneumo	13 months	
Diphtheria / Tetanus / Pertussis / Polio	Pre-school	
Measles / Mumps / Rubella	Pre-school	
HPV (girls) – 3 doses	12-13 years	
Dip/Tet/Polio	13-18 years	
Others – please state:		

All patients aged 16 or more, please complete the section on the next page

AUDIT Screening Tool

	AUDIT Questions	Scoring system					Write Your score here
		0	1	2	3	4	
AUDIT-C Questions 1-3	1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
	2. How many units of alcohol do you drink on a typical day when you are drinking?	0 - 2	3 - 4	5 - 6	7 - 9	10+	
	3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
AUDIT-C SCORE							
<u>If score is 5 or more continue with Questions 4-10</u>							

4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5	How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6	How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9	Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10	Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
AUDIT SCORE (Questions 4 – 10)							

We may contact you by letter or phone to discuss your responses to this screening tool.