NHS

Family doctor services registration *GMS 1*

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

☐ Mr ☐ Mrs ☐ Miss ☐ Ms — Surname

Date of birth | | | | | | | | — First Names

NHS No | | | | | | | | | | | — Previous surnames

☐ Male ☐ 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

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*

☐ I live more than 1 mile in a straight line from the nearest chemist
☐ I would have serious difficulty in getting them from a chemist

*Not all doctors are authorised to dispense medicines

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

☐ White British ☐ White other ☐ Mediterranean

☐ Middle East / North Africa ☐ Black Caribbean ☐ Black African

☐ Indian ☐ Pakistani ☐ Chinese

☐ Other Asian - please write details here:____

☐ Mixed White and Black Caribbean ☐ Mixed White and Black African ☐ Mixed White and Asian

☐ Any other ethnic group, mixed origin - please write details here:____

☐ Any other ethnic group - please write details here:____

First language if not English: ☐ Interpreter needed

☐ 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.nhscarerecords.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: Post Code:	Home Telephone No: Mobile Telephone No: ☐ I consent to receive text msgs about my appointments and care Email address: ☐ I consent to receive emails about my appointments and care

Next of Kin (please make sure you have their permission to give us this information)
Full Name/Title:
Full Address:
Relationship:
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: ☐
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.

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

☐ Diabetes	Date:	☐ Heart Problems	Date:
☐ Epilepsy	Date:	☐ Chronic Kidney Disease	Date:
☐ Thyroid problems	Date:	☐ Stroke	Date:
☐ High Cholesterol	Date:	☐ Asthma	Date:
☐ High Blood Pressure	Date:	☐ COPD	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:
(PLEASE NOTE: if you leave this blank we will remove any previously nominated pharmacies)

Allergies: Please list any allergies

Height / Weight Please complete if known:	Height	Weight

Special needs: ☐ Blind/sight impaired ☐ Deaf/hearing impaired ☐ Wheelchair user ☐ Learning disabled
☐ Other (please give details):

ADULTS ONLY

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

☐ I smoke __________________________ per day ☐ I used to smoke _________________ per day.

☐ I have never smoked. I stopped smoking ______________________________

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

Mother:		Father:		Siblings:	
	☐ Heart disease		☐ Heart disease		☐ Heart disease
	☐ Stroke		☐ Stroke		☐ Stroke
	☐ High Blood Pressure		☐ High Blood Pressure		☐ High Blood Pressure
	☐ Diabetes		☐ Diabetes		☐ Diabetes
	☐ Cancer		☐ Cancer		☐ Cancer
	☐ Other:		☐ Other:		☐ Other:

Are you a carer? YES / NO If yes please provide name and address:

Adult Immunisations

☐ Flu	Date given:	☐ Pneumonia	Date given:
☐ Tetanus	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 (only for certain babies at risk)	Birth	
First primary immunisations	2 months	
Second primary immunisations	3 months	
Third primary immunisations	4 months	
Hib-Meningitis C / Pneumo / Men B	12 months	
Measles / Mumps / Rubella (MMR)	12 months	
Preschool boosters	3 – 4 years	
MMR booster	3 – 4 years	
Flu	Age 2, 3 or 4	
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 **If score is 5 or more continue with Questions 4-10**	

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.