Rec Ints		EMIS No	

RETURNING TO UK OR OVERSEAS NATIONALS
FAMILY DOCTOR SERVICES REGISTRATION

Please complete in BLOCK Capitals

☐ Mr ☐ Mrs ☐ Miss ☐ Ms Surname……

Date of Birth ☐☐ ☐☐ ☐☐ (D D M M Y Y Y Y) First Names……

NHS ☐☐☐☐☐☐☐☐☐☐ Previous Surname……

☐ Male ☐ Female Town and Country of Birth……

Home Address……

……

Postcode…… Contact Details (Home Phone)……

(Mobile)…… Email……

Signature…… Date……

If you are from abroad

Your first address where you registered with a GP

……

……

……

Date you first came to live in the UK

……

If previously resident in UK, date of leaving

……

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death.
Please tick the boxes that apply

☐ Any of my organs and tissue or
☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ /tissue donation Date……/……/……

……

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood

☐ Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register Date……/……/……

……

NEW PATIENT HEALTH QUESTIONNAIRE

TO HELP US WITH YOUR PAST MEDICAL HISTORY WE WOLD BE GRATEFUL IF YOU COULD COMPLETE THIS QUESTIONNAIRE ALONG WITH ANYTHING ELSE YOU FEEL WE SHOULD KNOW

ALL INFORMATION IS TREATED WITH STRICT CONFIDENTIALTY

Please list any serious illness or operation you may have had, and the year in which it occurred

Please list any regular medication you are taking – including oral contraception

How many aerobic exercise session have you taken in the last week _____ (1 session = 20 minutes)

How tall are you? _____ How much do you weigh? _____ Blood Pressure _____

To record your up-to-date Blood Pressure please visit our POD room on the 1st floor where you can measure and record your own Blood Pressure. Our Floor 1 receptionist will be more than happy to help you.

WE CANNOT COMPLETE YOUR REGISTRATION WITHOUT THIS INFORMATION

Smoking

Do you smoke? YES / NO If yes, how many per day_____

If yes, please circle - Cigarettes – Tobacco – Cigars – Pipe

If current **non** smoker, have you ever smoked? YES / NO If yes, when did you stop? _____

We pride ourselves on helping, supporting and actively encouraging smokers to 'QUIT' and can provide one to one in house support and therapy.

Would you like one of Smoking Cessation Advisers to contact you with details of the help, support and advice available?

☐ Yes ☐ No If Yes, please supply your contact details. _____

PLEASE ENSURE YOU COMPLETE ALL THE RELEVANT INFORMATION IN THIS SECTION.

Are you allergic to any medicines – e.g. Penicillin or Aspirin

Female Patients only:

We recommend **ALL** female patients have a (PAP) smear test every 3 years between the ages of 25 – 65 (Every 5 years for age 50+).
Please book in **today** for a smear test with the Practice Nurse if your last smear was more than three years ago **or** taken privately or abroad and you do not have a copy of the result.

When was your last Cervical Smear? Date _____ Result: _____

Where was it taken? GP ☐ Clinic ☐ Hospital ☐ Private ☐ Abroad ☐ I've never had a smear test ☐

Next of Kin/Emergency Contact

Name:		**Relationship:**	
Home Tel No:		**Mobile Tel No:**	

In the event of an emergency can we contact the person named above? ☐ Yes ☐ No

Vaccinations

Please enter the dates of your last

TETANUS / POLIO	
MMR	
Meningitis	

Ethnicity: Please help us plan for the future healthcare of our population by providing information on your ethnicity

Please tick one box only

White	British	
	Irish	
	Any other White background	
Mixed	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other Mixed background	
Asian or Asian British	Indian	
	Pakistani	
	Bangladeshi	
	Any other Asian background	
Black or Black British	Caribbean	
	African	
	Any other Black background	
Other ethnic groups	Chinese	
	Any other ethnic group	
Decline to provide Ethnic Group		

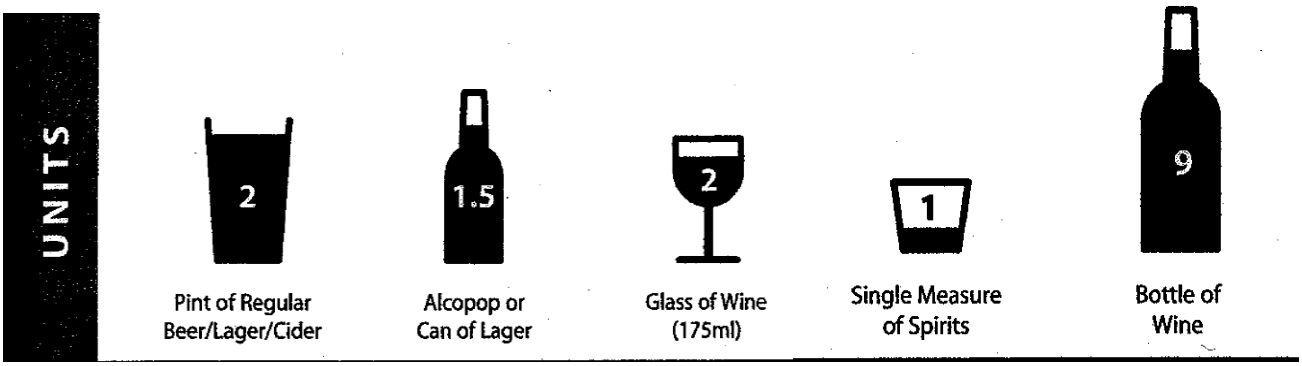
What is your 1st language _____

Any other appropriate information you feel would be useful

Please answer the first set of 3 questions – <u>AUDIT – C</u>

If your score is 5+ it may indicate hazardous or harmful drinking. Please then continue overleaf to the more detailed 10 question AUDIT screen.

You are very welcome to make an appointment with the nurse or doctor to discuss the above at any stage. In turn we may contact you if there are any concerns.



AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
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	

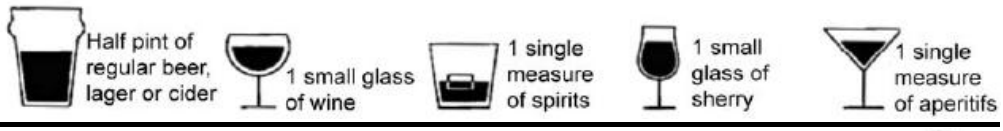
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

SCORE

<u>If your score is 5+ it may indicate hazardous or harmful drinking. Please then complete the more detailed 10 question AUDIT screen overleaf.</u>

Remaining AUDIT questions

This is one unit of alcohol…



…and each of these is more than one unit

AUDIT	Scoring system					Your score
	0	1	2	3	4	
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	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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	
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	
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	
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	
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	
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	
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	
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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Letter Issued	

SCORE