ID Seen: _____ **POA Seen: _____**

Today's Date:

PLEASE FILL OUT THE WHOLE FORM, PLEASE NOTE IT IS DOUBLE SIDED

Patient Details:

Title	
Surname	
First Name	
Date of birth (dd/mm/yyyy) – patients aged 40 and over please book an NHS Health Check	
Male/ Female	
Religion	
Main Language	
Do you need an interpreter? Please note that you must endeavour to bring your own interpreter as we have very limited availability	
Do you have any communication needs (e.g. reading, hearing, other?)	
If yes, please tell us how we can help (e.g. letters in large print, audio formation?)	

Contact Details:

Mobile Telephone	
Home Telephone	
E-mail Address	
Can we send appointment reminders via text?	Yes ☐ No ☐
Name of your 'next of kin' (someone we can contact in an emergency)	
Contact number of your next of kin	
Next of kin's relationship to you	

Would you be interested in registering for our Patient Access Service? Yes ☐

Patient Access gives you the freedom to book appointments, request repeat prescriptions and view parts of your medical records such as Immunisations via the smartphone app 'Patient Access' or from our website.

Optional Questions (this box only)

Please tick here if you are a gender reassignment patient ☐

Sexual Orientation:
Wish not to state ☐ Bisexual ☐ Heterosexual ☐ Lesbian ☐ Male Homosexual ☐

Are any members of your family registered with our practice?

Name	Relation to You?

About You:

Height	
Weight	
Do you smoke?	Yes ☐ No ☐
If yes, what do you smoke and how much?	
Are you an ex-smoker?	Yes ☐ No ☐
If yes, what did you smoke and how much?	

What kind of exercise do you do? (please tick one)

None ☐ Light (i.e. walking) ☐ Medium (i.e. jogging) ☐ Vigorous (i.e. Gym) ☐

How often do you exercise?

Never ☐ Occasionally ☐ 3-6 times a week ☐ Daily ☐

Allergies:

	YES	NO	DETAILS
Are you allergic to any medication?			
Are you allergic to anything else?			

Childhood Diseases:

	YES	NO
Chicken Pox		
Measles		
Mumps		

If you have an immunisation record, please let reception take a photocopy so we can update your medical records.

Would you be interested in being screened for any of the following, if so please let reception know: (you can show us discreetly by pointing to it)
HIV ☐ Chlamydia and Gonorrhoea ☐

Are you registered as disabled?	**Yes ☐ No ☐**	**Details:**

Past and Present Health

Do you have or have you ever suffered from any of the following? If yes, please give relevant details.

	YES	NO	DETAILS
Asthma/COPD			
Cancer			
Depression			
Diabetes			
Glaucoma			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Surgery/Operations			
Mental Illnesses			
Stoke/TIA			
TB			
HIV			
Other			

Family Health History

Do any of your family members suffer from any of the following – please state family member

	YES	NO	FAMILY MEMBER
Asthma/COPD			
Cancer			
Diabetes			
Glaucoma			
Hepatitis			
Mental Illness			
Stroke/TIA			
TB			

Do any of your family members have any of the following illnesses that started when they were under 60 years old?

	YES	NO	FAMILY MEMBER
Heart Disease			
High Blood Pressure			
High Cholesterol			

FEMALE ONLY QUESTIONS

Have you ever had a smear/pap test?	Yes ☐ No ☐
When did you have it?	
What was the result?	
If abnormal, did you receive a follow up appointment?	

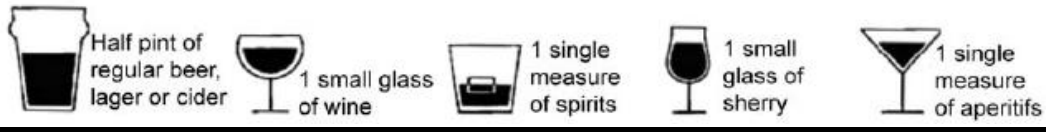
IF YOU HAVE RECENTLY RECEIVED A REMINDER LETTER FROM NHS ENGLAND – PLEASE BOOK FOR A CERVICAL SMEAR/PAP TEST TODAY

Drinking a sensible amount of alcohol is unlikely to do you any harm; however, for some people social drinking can lead to heavy drinking with can cause serious health problems. Please complete the following questionnaire.

If you do not drink alcohol, please tick the box below – <u>you do not need to complete the test.</u>

❑ I do not drink any alcohol

This is one unit of alcohol…



…and each of these is more than one unit

FAST	Scoring system					Your score
	0	1	2	3	4	
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 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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	

What to do next?

Scoring:
Add up the scores in the right hand column

If your **overall total score** is 2 or less, **<u>STOP</u>** - If your **overall total score** is **3 or more** complete the remaining AUDIT questions on the next page to obtain a full AUDIT score.

Score from FAST (other side)

Remaining AUDIT questions

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 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 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	
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	

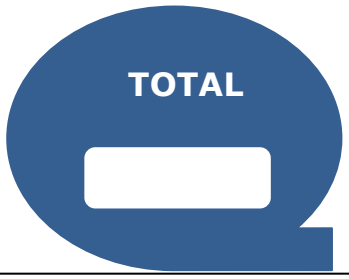
TOTAL AUDIT Score (all 10 questions completed):

0 – 7 Lower risk,

8 – 15 Increasing risk,

16 – 19 Higher risk,

20+ Possible dependence



Summary Care Record

A new system is available called the Summary Care Record (SCR). This system is designed to help both your GP and any emergency staff you contact when the surgery is closed treat your health needs more efficiently.

Your information will be shared between your GP practice, our local hospital and the Out of Hours Service. This will enable your GP surgery to access results and any visits you have at the hospital quickly and efficiently, but it also means that if you have an emergency and contact the out of hours service or visit A&E they have access to your current medications as well as allergies and are better able to treat you.

Your Options:

1. You want to have a summary Care Record. ☐
2. You do not want a summary care record. ☐

NAME:_____ DOB:_____

POSTCODE:_____ SIGNATURE:_____

DATE:_____

Care Data Extraction

Information about you and the care you receive is shared in a secure system by healthcare providers to support your treatment and care. It is important that the NHS can use this information to plan and improve services for all patients. They would like to link information from all the different places you receive care such as GP, Hospital and community services to provide a full picture. They will then compare this information to see what is working and what can be improved.

Information such as your postcode and NHS Number (not your name) will be used to link your records in a secure system, and can be used by researchers and those planning new health services.

If you wish for your information to be shared you do not have to sign anything as you are automatically signed up to this, however if you wish for your information NOT to be shared, you must sign below and we will enter a special code into your medical records to stop your information being shared.

1. I DO NOT want my health records from all the different places I receive care to be linked and shared. ☐

NAME: _____ DOB:_____

POSTCODE:_____ SIGNATURE:_____

DATE:_____