COMPUTER NUMBER **HEALTH CHECK ON YES** ☐

TB AT RISK COUNTRY? YES/NO **NAMED GP INFORMED YES** ☐

BLOOD BORNE VIRUS AT RISK COUNTRY?YES/NO

12 Sand Street
Huddersfield, HD1 3AL
Tel: 01484 430386

Surname/Family Name: .....

Forenames: .....

Date of Birth: .....

Contact Details

Telephone/Mobile Number .....

Email address .....

If you **do not** wish to receive SMS text messages please tick box ☐

Next of Kin (*Please give name and relationship of the person you would like us to contact in an emergency)*

Name ..... Relationship .....

Address .....

.....

Telephone number .....

Are you connected with the University? (Please circle which applies to you)

STUDENT / STAFF / FAMILY MEMBER OR PARTNER OF A STUDENT / NO UNIVERSITY CONNECTION

Have you previously been registered with the forces? Yes/No

Do you hold a European Health Insurance Card? Yes/No

PLEASE COMPLETE ALL SECTIONS

DRS MOUNSEY & RASAKUMARAN

NHS Family doctor services registration GMS1

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 surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

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

Your previous address in 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 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*

**Not all doctors are authorised to dispense medicines*

☐ 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

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

FIRST LANGUAGE SPOKEN		NATIONALITY	
ETHNICITY			
Please tick appropriate box below			
BRITISH OR MIXED BRITISH		INDIAN OR BRITISH INDIAN	
IRISH		PAKISTANI OR BRITISH PAKISTANI	
OTHER WHITE BACKGROUND		BANGLADESHI OR BRITISH BANGLADESHI	
WHITE AND BLACK CARIBBEAN		OTHER ASIAN BACKGROUND	
CARRIBEAN		OTHER BLACK BACKGROUND	
WHITE AND BLACK AFRICAN		OTHER MIXED BACKGROUND	
AFRICAN		CHINESE	
WHITE AND ASIAN		OTHER	
ETHNIC CATEGORY NOT STATED			

Have you any children? *(Please give names and dates of birth)*

Carers Information

Do you look after somebody? Yes/No

If yes who? .....

Does somebody look after you? Yes/No

If yes who? .....

Course of Study (Applies to Students ONLY)

Course ..... Date started .....

Student Identification number ..... Length of course .....

Patient Reference Group

We are currently seeking a small number of patients who would be willing to work with the Practice in such things as a patient survey and discussing services and improvements delivered by the Practice to meet the needs of its practice population.

Are you interested? Yes/No

PERSONAL MEDICAL HISTORY

PLEASE ANSWER ALL QUESTIONS

Do you see your doctor on a regular basis? Yes/No

DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS
(Please tick any condition you suffer from with the diagnosis date)

Asthma	Diagnosis Date .....
Diabetes	Diagnosis Date .....
Epilepsy	Diagnosis Date.....
Mental Health	Diagnosis Date.....
Depression	Diagnosis Date.....
Eating Disorders (Anorexia, Bulimia)	Diagnosis Date.....
Hypertension	Diagnosis Date.....
Cancer	Diagnosis Date.....
Heart Failure	Diagnosis Date.....
Chronic Kidney Disease (CKD)	Diagnosis Date.....
Atrial Fibrillation (AF)	Diagnosis Date.....
Dementia	Diagnosis Date.....
Osteoporosis	Diagnosis Date.....
Rheumatoid Arthritis	Diagnosis Date.....
Sickle Cell	Diagnosis Date.....
PCOS	Diagnosis Date.....
Peripheral Arterial Disease (PAD)	Diagnosis Date.....
Stroke/TIA	Diagnosis Date.....
Chronic Obstructive Pulmonary Disease (COPD)	Diagnosis Date.....
Coronary Heart Disease (CHD)	Diagnosis Date.....

Do you take any regular medication? Yes/No
(E.g. tablets/inhalers/creams)

Do you have any information or communication support needs, relating to a disability, impairment or sensory loss? If yes please detail below:

ALLERGIES: Do you have any allergies or adverse reactions to any medication or other substance? *(Please state the drug/substance and the reaction suffered with a date if known)*

IMMUNISATION STATUS

New Meningitiis ACWY vaccination for first time university entrants.

In response to a rapid and accelerated increase in cases of a highly aggressive form of meningococcal group W (MenW) disease, all new university entrants, including international students, if they are first year entrant and up to 25 years of age are strongly encouraged to be vaccinated.

New university entrants are at a particularly high risk in the first few weeks as they will be mixing with large groups of people some of whom unknowingly carry the meningococcal bacteria.

All first year university entrants as discussed above, who have not already been vaccinated against Men ACWY are strongly advised to be vaccinated on the day of registration at the Health Check.

MMR – If you have not had 2 MMR injections, then it is important that you have an MMR vaccination when you register.

IMMUNISATION STATUS – TO BE COMPLETED BY THE PATIENT

VACCINATIONS	DATE RECEIVED
Meningitis ACWY	
MMR	1st dose 2nd dose

TO BE COMPLETED BY THE PRACTICE NURSE

RECORD OF VACCINATIONS GIVEN AT HUDDERSFIELD UNIVERSITY HEALTH CENTRE				
DATE	VACCINE	BATCH NO	SITE GIVEN	GIVEN BY

COMMENT BOX FOR GP/PRACTICE NURSE

PATIENT CONSENT

The vaccination information I have given above is accurate. I take full responsibility for this and accept any recommended vaccinations.

Signed ..... Date .....
(Patient Signature)

PLEASE COMPLETE AS FULLY AS POSSIBLE

Height .....Weight .....BMI.....

Blood Pressure .....Any further action required.....

Dietary advice given? Yes/No

BMI >30 encouraged to attend Weight Reduction Programme? Yes/No

Prevention Offered? Yes/No Exercise advice given? Yes/No

SMOKING:

Do you smoke? Yes/No Have you ever smoked? Yes/No

How many cigarettes do you smoke per day?

Referral for Cessation Clinic? Yes/No Smoking advice given? Yes/No

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RECREATIONAL DRUGS:

Do you use any recreational drugs? Yes/No

Which recreational drugs do you use? Heroin/Solvents/Methadone/other Opiates .....

Lifestyle advice regarding drugs: Yes/No

CONTRACEPTIVE & SEXUAL HEALTH ADVICE: FOR BOTH MALE & FEMALE PATIENTS (including LARC)

Contraceptive advice given/Sexual health advice given? Yes/No

Are you sexually active Yes/No Are you using contraception Yes/No

Have you ever been tested for STI's? Yes/No Chlamydia Screening Offered? Yes/No

FEMALE PATIENTS ONLY

Type of Contraception: Pill/Depo/Condoms/Implanon/Coil/Patches/Other

CYTOLOGY

Have you ever had a smear? Yes/No

Aged 25+ Invite for cervical smear Yes/No

Date ..... Result ..... Place taken .....

PLEASE CIRCLE WHICH APPLIES TO YOU

UNITS OF ALCOHOL

Pint of beer/lager 4% ABV	2.3 units	Can of beer/lager 440 ml 5% ABV	2.2 units
175ml medium glass of wine 12% ABV	2 units	250ml large glass of wine 12% ABV	3 units
750ml bottle of wine 12% ABV	9 units	25ml single spirit and mixer 40% ABV	1 unit
50ml double spirit and mixer 40% ABV	2 units		

ALCOHOL USE DISORDERS INDENTIFICATION TEST (AUDIT)						
	QUESTIONS	Scoring System – Audit C				
		0	1	2	3	4
1	How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week
2	How many units do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+
3	How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4	How often in the last year have you not been able to stop drinking once you have started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	Have you or someone else been injured as a result of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
10	Has a relative / friend / /doctor/health worker been concerned about your drinking or advised you to cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Sensible/Increasing Risk/Higher Risk (please circle) **Action taken/advice given:**

MINI AUDIT SCORE [ ] FULL AUDIT SCORE [ ]

Screening Questionnaire To Check Your Mental Wellbeing

PLEASE CIRCLE WHICH APPLIES TO YOU

PHQ-9	Over the **last 2 weeks** (or other agreed time period) how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching the television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than ususal	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ-9 Total Score =			

GAD-7	Over the **last 2 weeks** (or other agreed time period) how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.	Feeling nervours, anxious or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it is hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3
		GAD-7 total score =			

FAMILY HISTORY:
Has anyone in your immediate family suffered from?

HEART DISEASE:	Under 60 Over 60 (Please circle)	Family member .....
STROKE:	Yes/No	Family member .....
DIABETES:	Yes/No	Family member.....
HIGH BLOOD PRESSURE:	Yes/No	Family member .....

For office use only

HEALTH CHECK DONE BY (HCA/Nurse signature) .....

DATE.....

MINI HEALTH CHECK DONE BY (HCA/Nurse signature).....

DATE.....

ELECTRONIC HEALTH RECORD ACCESS

WHAT IS COERCION?

"Coercion" is the act of governing the actions of another force or by threat, in order to overwhelm and compel that individual to act against their will.

Online services of all types are vulnerable to coercion. In the context of Patient Online, coercion might result in patients being **forced** into sharing information from their medical record, including login details, medical history, repeat prescription orders, GP appointment booking details and other private, personal information.

Would someone else ask for your access to your medical information if you were given on-line access?

Yes ☐ No ☐

Signed _____ Date_____

We are able to offer full access to your medical records, if you are interested in this service please speak to the reception staff or visit our website for more information.

Important Information About Your Summary Care Record

The NHS in England has introduced the Summary Care Record, an electronic health record that can be accessed when you need urgent treatment from somebody other than your own GP.

Summary Care Records contain key information about the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. You will be able to add other information too if you and your GP agree that it is a good idea to do so.

If you have an accident or fall ill, the people caring for you in places like accident and emergency departments and GP out of hours services will be better equipped to treat you if they have this information. Your Summary Care Record will be available to authorised healthcare staff whenever and wherever you need treatment in England, and they will ask your permission before they look at it.

You need to make a decision

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

• **Yes, I would like a Summary Care Record.** If you want a record you do not need to do anything further, one will be created for you. If you have opted out of having a record in the past but have now changed your mind, speak to your GP practice and they can create one for you.

• **No, I do not want a Summary Care Record.** If you do not want a record, you need to fill in the Summary Care Record opt out form on the next page. You should do this even if you have already completed a form at your previous practice.

You are free to change your decision at any time by informing your GP practice.

Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, please tell them about Summary Care Records and explain the options available to them.

For more information ask at reception, or call the Health and Social Care Information Centre on 0300 303 5678.

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you DO NOT want a Summary Care Record please fill out the form and send 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 another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details 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.

If you have any questions, or if you want to discuss your choices, please:
- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes/no Date.....

Ref: 4705

For office use only

	Tick Box		Tick Box
MINI HEALTH CHECK DONE **Needs Immunisations** PINK CARD		**Immunisations done**	
Needs full health check GREEN CARD		**Full health check done**	
Needs Immunisations YELLOW CARD		**Immunisations done**	
Needs TB Testing WHITE CARD		**TB Testing done**	
Needs BBV RED CARD		**BBV done**	
CHRONIC NEEDS TO SEE GP		**Patient in waiting room to see GP** **Notes handed to reception**	
CHRONIC SEEN BY GP **Needs Immunisations** YELLOW CARD GIVEN BY NURSE		**GP to send to Minor Surgery to queue for Immunisations**	
TB High Risk WHITE CARD GIVEN BY NURSE		**Needs Mantoux- GP to send to reception**	
Needs BBV RED CARD GIVEN BY NURSE		**Ask to join queue from 1st floor staff stairs to treatment rooms**	