Family doctor registration form

The White Horse Medical Practice

This information will remain strictly confidential. Please make sure you sign the form.

Surname	Town and Country of Birth
First Name(s)	Sex: Male/Female
Previous surname	Title: Mr/Mrs/Miss/Ms/Dr/
NHS number	Single/ married/ co-habiting/ separated/divorced/ widowed
Date of birth	Occupation
Address	Home telephone number
	Work telephone number
Post code	Mobile telephone number

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

Your previous address in UK:	Name of previous doctor	
	Address of previous doctor	
Post code		
If you are from abroad, your first UK address where registered with a GP	Service or Personnel Number	
First date of entry to the UK	Enlistment date	Leaving date

If you need your doctor to dispense medicines and appliances

☐ I live more than 1 mile in a straight mile from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

Have you ever been registered here before? YES/NO

Ethnic origin & Language – please indicate which ethnic group you belong to & main language spoken. This is important information to help us understand better the health needs of our patients

White	British Any other white background (please specify)	
Mixed	Any mixed background (please specify)	
Asian	Indian Pakistani Bangladeshi Chinese Any other Asian background (please specify)	
Black	Caribbean African Any other Black background (please specify)	
Other ethnic background	Any other background (please specify)	
Language Spoken	English	Other (please specify)

Your health

Please list any serious illnesses, accidents, operations, with the year they happened and the name of the hospital is appropriate:

Year	Condition	Hospital	Operation/illness

Are you currently under the care of a hospital specialist? Please specify:
…………………………………………………………………………………………………..
Are you currently on a hospital waiting list?…………………………………………………..

Do you currently have, or have you ever suffered from any of the following?

Asthma	YES/NO
Blindness/Glaucoma	YES/NO
Bronchitis	YES/NO
Cancer	YES/NO
Depression	YES/NO
Eczema	YES/NO
Thyroid problems	YES/NO

Stroke	YES/NO
Diabetes	YES/NO
Epilepsy	YES/NO
Hay fever	YES/NO
Heart attack	YES/NO
High blood pressure	YES/NO
Mental health problems	YES/NO

Are you taking any drugs or medicines prescribed by a doctor? YES/NO
If yes, please give details below:

Name of medicine/tablets	Dose or strength	How many a day?

Are you currently taking any medicine ***not*** prescribed by a doctor? YES/NO
If yes, please specify ……………………………………………………………………………………………

Are you allergic to anything? YES/NO If yes, please specify …………………………………………………

Do you smoke? YES/NO If yes, how many cigarettes a day?…………………………………….

If you have given up, when did you give up?…………………………………………………………………..

What is your weekly consumption of alcohol. Please tick the relevant box below

None or very occasional	
Moderate (less than 21 units for a man or 14 units for a woman)	
Above average (21-35 units for a man, 14-28 units for a woman)	
Heavy (more than 35 units for a man, more than 28 units for a woman	

(One unit is ½ pint of beer or a single measure of spirits or one glass of wine)

Have you been immunised against the following? If so please state the date:

Tetanus	Date:
Polio	Date:
Others (please specify)	Date:
Others (please specify)	Date

Have any of your relatives suffered the following conditions under the age of 60?

Heart disease	YES/NO	Stroke	YES/NO	High blood pressure	YES/NO

Is there a family history of any other illnesses?……………………………………………………………..

What is your current weight? ………….. What is your height?………………….

Please circle the word below that best describes your diet:

Healthy | Average | Poor

How much exercise do you take? Please circle the word that best describes this.

Inactive | Moderate | Vigorous

Are you a carer of someone else? Who? (Name and telephone number if a patient here)

……….

Are you cared for by someone else? Who? (Name and telephone number)

……….

FOR WOMEN ONLY

How many pregnancies have you had?………………………………………………………………………
Did you have any difficulties (eg miscarriage, still-born child, difficult delivery etc) YES/NO
If yes, please specify……………………………………………………………………………………….

Are you taking oral contraceptives? YES/NO
If yes, which brand and how long have you been taking it?…………………………………………………

Any previous brand of oral contraceptive? YES/NO If yes please specify………………………………
If not using oral contraceptives are you using any other birth control? YES/NO
Which method?…………………………………………………………………………………………………

Have you ever had a cervical smear test? YES/NO If yes, when was this last done?
Date? Year?……………………………………………………………………………………………………

Have you ever had a breast screening test or mammography? YES/NO. If yes, when was the last time this was done? Date? Year? ……………………………………………………………………………….

Have you had a hysterectomy? YES/NO. If yes, when was this done?……………………………………..

Signature of patient………..……………………………… Date…………………………..

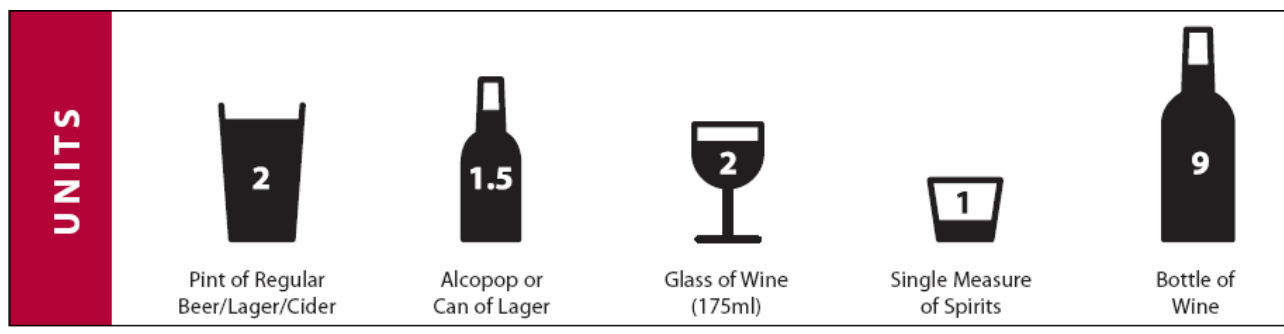
Signature on behalf of patient ……………………………… Date…………………………..

Fast Alcohol Screening Test (FAST)

Please complete the following questions as honestly as possible!

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly, weekly or daily						
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	
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	
Has a relative, friend, doctor or health-worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: A total of 3+ indicates hazardous or harmful drinking



Thank you for completing this form

Summary Care Record and Oxfordshire Care Summary – your choice

Please note that these records are ***NOT CONNECTED*** with the Health and Social Care Information Centre (HSCIC) single database care.data project, and will be used ***only*** for the purpose of enabling informed care to be supplied directly to you as an individual.

Your patient record is held securely and confidentially on the electronic system at your GP practice.
If you require treatment in another NHS healthcare setting such as an Emergency Department or Minor Injury Unit, those treating you would be better able to give you appropriate care if some of the information from the GP practice were available to them.
This information can now be shared electronically via:

1. **The Summary Care Record:** used nationally across England
2. **The Oxfordshire Care Summary:** used locally across Oxfordshire

In both cases, the information will be used ***only by authorised health care professionals directly involved in your care***.
Your permission will be asked before the information is accessed, unless the clinician is unable to ask you and there is a clinical reason for access.

For more details of both records, please see overleaf.

A parent or guardian can request to opt out children under 16 but ultimately it is the GP's decision whether to create the records or not, because of their duty of care to the child. If you are the parent or guardian of a child under 16 and feel that they are able to understand, then you should make this information available to them.

Are you happy for us to share this electronic information with clinicians in other NHS organisations who are involved in your care? If you would rather we didn't, we will put an entry on your record which will prevent your information from being shared.

Please select ONE option in the tables below and complete patient details overleaf.

Your choice for SCR	***Please tick one box only***
I would like my information shared through the Summary Care Record	
I do ***not*** want my information shared through the Summary Care Record	

Your choice for OCS	***Please tick one box only***
I would like my information shared through the Oxfordshire Care Summary	
I do ***not*** want my information shared through the Oxfordshire Care Summary	

It is important to complete and return this form, as your new practice cannot make a decision for you. Without your direction, we cannot guarantee that your wishes will be met, even if you have previously made a similar choice in another practice.

Patient details **(please write in CAPITAL LETTERS)**			
Title:		**Forenames:**	
Surname/Family name:			
Address:			
Phone number(s):			
Date of birth:		**NHS number (if known):**	
***If the person signing below is not the patient, please also enter the signatory's name and relationship to the patient, e.g.* PARENT, GUARDIAN, ATTORNEY**			
Full name:		**Status:**	
Signature:		**Date:-**	

Differences between the Oxfordshire Care Summary and the Summary Care Record		
	Oxfordshire Care Summary	**Summary Care Record**
Shared	• Across Oxfordshire • Across health care settings, including urgent care, community care and outpatient departments • With GPs, and with clinicians employed by Oxford Health NHS Foundation Trust and Oxford University Hospitals Trust	• Across England • Across health care settings, including urgent care, community care and outpatient departments • With GPs, and with clinicians employed by Oxford Health NHS Foundation Trust and Oxford University Hospitals Trust
Information source	• GP record • Other medical records held by different NHS organisations in Oxfordshire	• GP record
Content	• Your current medications • Any allergies you have • Any bad reactions you have had to medicines • Your medical history and diagnoses • Test results and X-ray reports • Your vaccination history • General health readings such as blood pressure • Your appointments, hospital admissions, GP out-of-hours attendances and ambulance calls • Care / management plans • Correspondence such as referral letters and discharge summaries.	• Your current medications • Any allergies you have • Any bad reactions you have had to medicines • Additional information (upon request to your GP)
For more information, visit:	• http://www.oxfordshireccg.nhs.uk/your-health/oxfordshire-care-summary/	• www.nhscarerecords.nhs.uk • http://www.oxfordshireccg.nhs.uk/your-health/summary-care-record/