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| --- | --- | --- |
| Full Name:  Date of Birth: | Title:  Mr  Mrs  Miss  Ms  Other (please state): | |
| Please state your birth gender?  Male  Female  Is your gender identity the same as the sex you were assigned at birth?  Yes  No  Prefer not to say | Marital status:  Single  Married  Divorced | Widowed  Separated  Co-Habiting |
| **NEXT OF KIN** | | |
| Name:  Relationship to you: | Contact Details: |  |
| Do you have a Carer?  Yes  No – If yes, please give carer’s details | | |
| Name: | Contact Details: | |
| **CONTACT DETAILS** | | |
| Email:  Wherever possible we prefer to send out information via email, this will include your new patient registration information and your Patient Access PIN document, should you choose to sign up to the service.  Are you happy to receive emails from us?  Yes  No | Mobile:  We offer an appointment reminder SMS messaging system. This will also include general health information and Practice information such as changes to opening times, simple health status questions and recalling patients for chronic disease management.  Are you happy to receive SMS messages from us?  Yes  No | |
| Please state your preferred method of contact:  Email  SMS (text)  Mobile Tele.  Home Tele (please state)………………………………. | | |

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| **ONLINE SERVICES** |
| **Patient Access and NHS app**  We offer online services to all patients, this can be accessed via Patient Access or the NHS app. This allows you to;   * Order repeat prescriptions * Change your contact details * View your full medical record (from date of registration onwards)   If you wish to subscribe to this service, please complete the Online Registration form on page 6.  **Ask First**  We work closely with Ask First enabling patients to perform the following tasks;   * Check your symptoms * Book appointments * Make general enquiries / administrative requests * Find local services   You can download the app in your app store (iOS) or Google Play (Android) by searching ‘Ask First’ |

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| **PREVIOUS DETAILS** | | |
| So we can ensure that we have your full medical record, please provide us with any previous names you may have held, your last three addresses in the UK and your last three addresses (if applicable).  It is vital that we have your full medical record, this is important so we can maintain screening programmes, provide you with the best care and keep your medical records complete.  Primary Care Service England (PCSE) will pause your registration with the practice if they find a possible match to your demographics on the NHS Spine, therefore providing us with this information now can prevent this from happening. | | |
| PREVIOUS NAME(S): | | |
|  | | |
| PREVIOUS ADDRESS(ES): | | |
|  |  |  |
| PREVIOUS GP PRACTICE(S): | | |
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| Have you ever served in the UK armed forces or were registered with a Ministry of Defence GP in the UK or Overseas?  Yes  No  Prefer not to say  If yes, please state which:  *(if you were given a FMED133A or FMED31 form when you left the UK armed forces, you should give this to your GP surgery)* | | |

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| **PUBLIC HEALTH STATISTICS** | | | | | | | | | | | | |
| **Your Religion** | | | | | | | | | | | | |
| Buddhist  Hindu  Muslim | | Catholic  Jehovah’s Witness  No religion | | | | | | Christian  Jewish  Other: | | | | |
| **Your Ethnic Origin** | | | | | | | | | | | | |
| White British  Black African / British  Arabic  Other Mixed Background | White Irish  Other Black Background  Bangladeshi / British  Other, please state: | | | White Other  Indian / British Indian  Chinese | | | | | | Black Caribbean / British  Pakistani / British  Other Asian Background  Ethnic Category Refused | | |
| **What is your main spoken language?**  *Please state below;* | | | | **Do you use an Interpreting app on your phone?**  **Yes**  **No**  **Do you require an Interpreter present at appointments?**  Yes  No | | | | | | | | |
| **Do you speak English?**  Yes  No | | | |
| **Your Occupation:** | | | | | | | | | | | | |
| **HEALTH INFORMATION** | | | | | | | | | | | | |
| **Weight:** | **Height:** | | | | | **How much exercise do you do?** | | | | | | |
| None | | | | Light | | |
| Moderate | | | | Vigorous | | |
| **Do you smoke?**  Non Smoker  Vape with Nicotine | Ex-Cigarette Smoker  Vape without Nicotine | | | | | Current Cigarette Smoker,  If so, how many a day?……………………… | | | | | | |
| If you are a smoker and want to STOP please tick here | | | | | | | | | | | | |
| FAST (Alcohol Screening Test) | | | | | | | | | | | | |
| **Questions** | | | **Scoring system** | | | | | | | | | **Your score** |
| 0 | | 1 | | 2 | | 3 | | 4 |
| How often have you had 6 or more units if female, or 8 or more units if male, on a single occasion in the last year? | | | Never | | Less than  monthly | | Monthly | | Weekly | | Daily or almost daily |  |
| **Only answer the following questions if the answer above is Monthly (2) or Less than monthly (1).**  **Stop here if the answer is Never (0), Weekly (3) or Daily (4).** | | | | | | | | | | | | |
| 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 |  |
| Scoring:   * A score of 0 on the first question indicates FAST negative. * A total of 1 – 2 on the first question then continue with the next three questions * A total of 3 – 4 on the first question stop screening at first question, this is a positive screen, move to AUDIT below. * An overall total score of 3 or above is FAST positive. Move onto AUDIT below. | | | | | | | | | | | | **TOTAL** |
| AUDIT | | | | | | | | | | | | |
| **Questions** | | | **Scoring system** | | | | | | | | | **Your score** |
| 0 | | 1 | | 2 | | 3 | | 4 |
| How often do you have a drink containing alcohol? | | | Never | | Less than  monthly | | 2 -4 times per week | | 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 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 |  |
| Scoring:  0-7 Lower Risk 8-15 Increasing Risk  16-19 Higher Risk 20+ Possible dependence | | | | | | | | | | | | **TOTAL** |
| **MEDICAL BACKGROUND** | | | | | | | | | | | | |
| **Do you have any disabilities?** | | | | | | | | | | | | |
| **Do you have any drug or food allergies? Please list:** | | | | | | | | | | | | |
| **Do you have any personal history of any of the following:**  Diabetes Mellitus  Yes  No  Respiratory Disease (inc. Asthma)  Yes  No  Stroke/TIA  Yes  No  Heart Attack (less than 60)  Yes  No  Heart Attack (greater than 60)  Yes  No  Angina  Yes  No  Ongoing Mental Illness  Yes  No  Hypertension  Yes  No  Please state any other health conditions we need to be aware of; | | | | | | | | | | | | |
| **WOMEN ONLY (Aged 25 years and over)** | | | | | | | | | | | | |
| What is the date of your last cervical smear test? | | | | | | | | | | | | |
| Please provide the result if known: | | | | | | | | | | | | |

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| **FAMILY HISTORY** |
| **Do you have a family history of any of the following?**  Diabetes Mellitus  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Heart Attack  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Stroke/TIA  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Angina  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Hypertension (High Blood Pressure)  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Breast Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Ovarian Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Bowel Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Lung Cancer  Yes, relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  Any other form of Cancer (please state): ..………………………………………………………………………………………………. |

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| **REPEAT MEDICATIONS** | | | | | |
| **Are you taking any regular medications? If so please give details in the box below;**  *If you are taking more than 10 repeat medications, please attach a list.* | | | | | |
| **Medication Name**  (Generic not branded) | | | **Dosage** | | **Quantity left** |
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| **! IMPORTANT INFORMATION REGARDING MEDICATIONS !**   * You MUST have a medication review before we are able to issue any medications. An appointment will be sent to you via SMS or letter following your registration. * If you are coming from abroad, please have your medication information translated and provide evidence that you are taking this with your registration papers. | | | | | |
| **We now send prescriptions electronically (EPS) to a Pharmacy of your choice. Please pick your desired Pharmacy below;** | | | | | |
| Rowlands  Boots Hale Leys  Hampden Gardens  Pharmacy 2 U | Consult  Boots Walton Court  Buckingham Park  Other ……………………. | Tesco Tring Road  Morrisons  Lloyds Bedgrove | | Tesco Broadfields  Lansdale  Lloyds Meadowcroft | |

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| **OTHER INFORMATION** | |
| Do you have a “Living Will”?  *A statement which explains what medical treatment you would not want in the future* | Yes – Please provide a copy  No |
| Do you have a DNACPR in place?  *Resuscitation Status* | Yes – Please provide a copy  No |
| Have you appointed a Power of Attorney?  *Legal document naming a person to act on your behalf regarding your health and welfare* | Yes – Please provide a copy  No |
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| Icon  Description automatically generated with low confidence**POPLAR GROVE PRACTICE, MEADOW WAY,**  **AYLESBURY, BUCKS, HP20 1XB** |

**Patient Online: registration form Access to GP online services**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Date of birth |  | | |
| Address |  | | |
| Postcode |  | | |
| Email address |  | | |
| Telephone number |  | Mobile number |  |

# *\*Available at this GP Practice from 1st April 2016. Existing patients will be able to see their medical record items entered on/after 01/04/2016. New patients from date of registration onwards.*

I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement. | 🞏 |
| 1. If I see information in my record that it not about me or is inaccurate, I will log out immediately and contact the practice as per process available on their website. | 🞏 |

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| --- | --- | --- | --- |
| Signature |  | Date |  |

### For practice use only:

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through  (tick all that apply) | Vouching 🞏  Vouching with information in record 🞏  Photo ID 🞏  Proof of residence 🞏 | Name of verifier | Date |
| Name of person who created account |  | | |
| Date account created |  | | |
| Date linkage key sent |  | | |