Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other

……

CONFIDENTIAL MEDICAL REGISTRATION FORM

Please complete all pages in FULL using BLOCK capitals Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

Your contact details will be used for adminstration purposes, such as sending texts/emails about appointments, routine tests, reminders. If you do not want your details to be used for these purposes, plesae speak to a member of our Reception team.

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

Your previous address in UK

Post Code:

Name of previous Doctor while at that address

Address of previous Doctor

Post Code:

Where did you last receive treatment? Date:

ie GP, Walk in Centre, MIU, Emergency Department etc

What was the outcome of this visit? ie prescription

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK

date of leaving

Date you first came to UK

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

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

If you are returning from the Armed Forces:

Addresss before enlisting

Post Code:

Enlistment date

Service/ Personnel number

NHS Organ Donor registration:

Practices will no longer be able to record this information and patients should visit the organ donation website to make their choices. If you would like to speak to somebody about your choices, please call the NHS dedicated line: **0300 123 23 23.**

The Organ Donation opt out system in England came into effect on 20 May 2020. This means that all adults in England will be considered to have agreed to be an organ donor when they die unless they have recorded a decision not to donate or are in one of the excluded groups below:

- Those under the age of 18
- People who lack the mental capacity to understand the new arrangements and take the necessary action
- Visitors to England, and those not living here voluntarily
- People who have lived in England for less than 12 months before their death

You still have a choice whether or not you wish to become a donor. Get the facts about organ donation to help you decide.

More information can also be found at https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-inengland/

NHS Blood Donor registration:

If you would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood please visit Home - NHS Blood Donation or call 0300 123 23 23

Patient Declaration for all patients who are not ordinarily resident in the UK

Please see appendix 1 for patient declaration (last page of form)

Please tell us about yourself:

Are you a carer? ☐ Yes ☐ No Do you have a carer? ☐ Yes ☐ No

If yes, please tell us the name & address of your Carer:

Are you happy for us to contact your carer ☐ Yes ☐ No about you?

For patients aged 85 or over: (these are to help us assess if you may need additional clinical input)

In general, do you have any health problems that require you to limit your activities? ☐ Yes ☐ No
In general, do you have any health problems that require you to stay at home? ☐ Yes ☐ No
Do you regularly use a stick, walker or wheelchair to get about? ☐ Yes ☐ No
In case of need, can you count on someone close to you? ☐ Yes ☐ No
Do you need someone to help you on a regular basis? ☐ Yes ☐ No

Please provide details if the person is different from the information you have provided as your carer.

Personal Medical History…..

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	Year diagnosed	Ongoing
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following:
(please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Immunsation	Year	Immunisation	Year
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

List of current medication ……

If you have a copy of your repeat medications, please pass to Reception to copy

Name of medication	Dosage

Lifestyle ……

Please enter your height & weight:

Height:	Weight:

Lifestyle smoking ……

Do you smoke: ☐ Yes ☐ No

If yes, do you smoke: ☐ Cigarette ☐ Cigars ☐ Pipe

Are you an ex-smoker? ☐ Yes ☐ No

When did you give up?

How many cigarettes/ cigars do you smoke daily? ☐ <1/day ☐ 1-9/day ☐ 10-19/day ☐ 20-39/day ☐ 40+/day

If you smoke a pipe

Would you like help to quit smoking? ☐ Yes ☐ No

how many ounces a week?

Lifestyle alcohol ……

Do you drink alcohol: ☐ Yes ☐ No If yes, please answer the following questions:

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

How many standard alcoholic drinks do you have on a typical day when you are drinking? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 10+

How often do you have 6 or more standard drinks on one occasion? ☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Lifestyle exercise ……

Do you exercise: ☐ Yes ☐ No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

Are you currently, or think you may be pregnant? ☐ Yes ☐ No

Female patients only ……

Do you have any children? ☐ Yes ☐ No If yes, how many?

Which method of contraception (if any) are you using at present?

Have you had a cervical smear test? ☐ Yes ☐ No If yes, what was the result? (if known)
Date (if known)

Ethnicity ……

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other (please state):
☐ Decline to state

Next of kin ……

Name: Tel. contact number:

Relationship:

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Signature ……

I confirm that the information I have provided is true to the best of my knowledge.

Signed: Date:

Signature of patient ☐ Signature on behalf of patient ☐

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

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

SUPPLEMENTARY QUESTIONS

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** ☐ **NO:** ☐	If yes, please enter details from your EHIC or PRC below:
 *If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.*	Country Code: (D)	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Scan and send this page of form to: NHSDigital-EHIC@nhs.net

The Old Fire Station Surgery, 68a Portsmouth Road, Woolston, Southampton SO19 9AN

Updated 02/06/2020

Dr A M Purcell Dr K Malone Dr Lockwood Dr Blunden Dr Harding Dr Ku

In order for us to provide you with the best medical care, please complete this questionnaire. Please circle if there is a particular Doctor you would like to be registered with.

Personal Details

Name	
Sex	Male / Female
Date of Birth	
Marital Status	
Place of Birth	
Ethnic Origin	
Religion	
Have you been registered at this surgery before?	YES / NO
Telephone: Home	
Mobile	
Work	
Email Address	
Would you consent to being contacted by the surgery via	E-mail YES / NO Text YES / NO
Occupation or Name and Address of School	
Next of Kin (*Please supply name, address, telephone number and relationship*)	
Are you a carer? If yes, who do you care for and why? What care do you provide?	
Do you have a carer?	
What is your first language?	
Do you require an interpreter?	

Family History

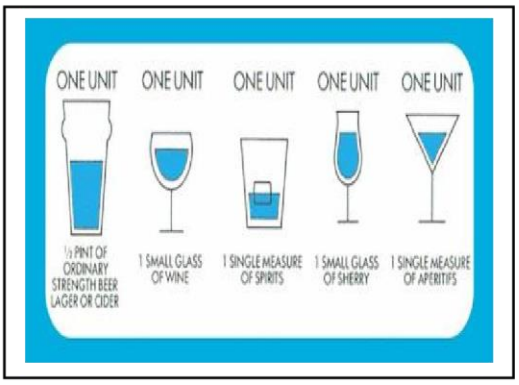
Do any members of your immediate family have any of the following? (i.e. mother, father, brothers, sisters, grandparents)	**Illnesses**	**YES / NO**	**Family member, age diagnosed and details**
	Heart disease		
	Stroke		
	Diabetes		
	Asthma		
	Cancer		
	High Blood pressure		
	Glaucoma		

Medical Information

List any illness you have had in the past or are taking regular medication for at present.	
Are you on any regular medication?	
Do you currently have your prescription sent straight to a pharmacy for dispensing?	YES / NO
If this request is from your old surgery do we need to remove the pharmacy from your records?	YES / NO
Which local pharmacy do you want to have your script sent to?	
Are you currently under the care of any specialist? (If 'YES', please give name, speciality and hospital).	
Are you allergic to any drugs or medicines? If 'YES', please list drug and the reaction it caused.	

ALCOHOL CONSUMPTION

		Please tick
How often do you have a drink containing alcohol?	Never	
	Monthly or less	
	2-4 times a month	
	2-3 times a week	
	4 or more times a week	
How many units of alcohol do you drink on a typical day when you are drinking?	N/A	
	1 or 2	
	3 or 4	
	5 or 6	
	7 or 8	
	10 or more	
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?	N/A	
	Never	
	Less than monthly	
	Monthly	
	Weekly	
	Daily or almost daily	
If we require more information regarding your alcohol consumption would it be okay for us to send you a further questionnaire?	Yes	
	No	



Do you smoke?	YES / NO	**If you smoke and would like some help in giving up, please contact "Healthy Living Southampton" on 0300 1233791, or make an appointment with your GP.**
If 'YES', how many do you smoke a day	…….. per day	
Are you an ex-smoker?	YES /NO	
When did you stop smoking?		

Female only

What form of contraception do you use?	
When did you have your last cervical smear?	

Please tick this box if you would like to be involved in our Patient Representative Group. This involves receiving 2-3 e-mailed surveys yearly and is a great opportunity to give your views and opinions to the surgery.

If you are already registered at another local surgery and want to register here without changing address please give an explanation why.