COMPUTER NUMBER **HEALTH CHECK ON YES** ☐
NAMED GP INFORMED YES ☐

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 wish to opt in to receive SMS text/email messages from the Practice please tick box ☐

Next of Kin – Name……..Contact No:……

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

Carers Information

Do you look after somebody? Yes/No - If yes who? ……..

Does somebody look after you? Yes/No – If yes who? ……

You have the right to confidentiality under the Data Protection Act 1998 (DPA). The General Data Protection Regulations 2018, The Human Rights Act 1998 and the Common law duty of confidentiality. Please see our website for further information http://www.universityhealthhuddersfield.co.uk/

INSERT PAGE
[GMS1 FIRST PAGE]

PLEASE COMPLETE ALL SECTIONS

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			

PLEASE ANSWER ALL QUESTIONS

DO YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS
PERSONAL MEDICAL HISTORY
(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)

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)*

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

BLOOD BORNE VIRUS / TB (Applies to International patients ONLY)

TB/BBV at risk country? YES / NO
Referral to TB screening? YES / NO

Blood Borne Virus/TB screening declined? YES / HAD 3 MONTHS AGO / NO

HIV/Hep B/Hep C screening offered? YES / NO

IMMUNISATION STATUS

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

ACWY – If you have not had 2 ACWY 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

---

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

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

Contraception offered? Yes/No

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)						
		Scoring System – Audit C				
	QUESTIONS	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 ☐

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…….

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.

General Data Protection Regulations
CONSENT FORM

Name …….. DOB…….

I hereby give consent under the new General Data Protection Regulations 2018 for :-

Please tick √

- ☐ **My medication to be ordered**
- ☐ **Prescriptions, letters & sick notes to be collected**
- ☐ **Appointments made on my behalf/referral to secondary care (hospital appointments etc)**

Signature ……..…

Date ……

It is the responsibility of the patient to inform the practiced of any change of personal data under the new General Data Protection Regulations 2018. You have the right to withdraw your consent at any time.

Thank you

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.

INSERT DOCUMENT

[SUMMARY CARE RECORDS OPT OUT FORM]