LYME BAY MEDICAL PRACTICE

**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

Post Code:

Address

Telephone number: Mobile number:

Email address:

**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

Post Code:

Address of previous Doctor

**If you are from abroad**

Your first UK address where

Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

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

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

**If you are returning from the Armed Forces:**

Addresss before enlisting

Post Code:

Enlistment date Service/ Personnel number

***Were you ever in the armed forces****?* **Yes ☐ No ☐**

**Next of kin ……**

**vej**

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Tel. contact number |
|  |  |  |
|  |  |  |

**Data sharing consent choices ……**

**vej**

**SUMMARY CARE RECORD (SCR)**: your basic details are uploaded to the national NHS database and can be viewed by other health professionals in an emergency (see leaflet).

**ENHANCED SHARE:** your full medical record can be viewed electronically by some healthcare professional treating you elsewhere but using the same clinical system, such as Dorset Minor Injuries Units and district nurses.

**Summary care Record**  I would like **(please tick one):**

A Summary Care Record containing details of my Medications,

Allergies, any Bad Reactions to Medication AND any ☐Additional Information (Enhanced share)useful for my care. ☐

I do **not** want to have a Summary Care Record (opt out). ☐

**SystmOne Sharing –**

I do **not** agree to the sharing of my information for the purposes of my care ☐

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

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other

**Where would you like your prescriptions to go to?**

Boots Lyme Regis 🞏

Charmouth Pharmacy 🞏

Lloyds Lyme Regis 🞏

Other (please write including town) …………………………………………………………

**Communications:** if it is ok for us to leave messages on your home answerphone please tick:

What is your preferred contact method: **🗆 text 🗆 email 🗆 letter**

What is your preferred contact number **🗆 home 🗆 mobile 🗆 other……………………………….**

Do you consent to receiving text messages from us? 🞏 Yes 🞏 No

***Allocated GP***

*All our patients are free to see any GP of their choice, but each patient has a named accountable GP, her Dr Forbes Watson on their clinical record. This GP has overall responsibility for your care, but you can request an appointment with any doctor that is available.*

**Ethnicity ……**

**vej**

Please indicate your ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Decline to state

## **First Language spoken ……………………………………………………………………………………..**

**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 who

you care for or who cares for you

Are you happy for us to contact your carer 🞏 Yes 🞏 No

about you?

**Family History…..**

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer (please state what sort of cancer) |
|  |  |  |  |  |  |  |

**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/ 🞏 <1/day 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

cigars do you smoke

daily?

If you smoke a pipe Would you like help 🞏 Yes 🞏 No

how many ounces a to quit smoking?

week?

**Lifestyle alcohol ……**

How many units of alcohol do you drink a week……………………….

**This is one unit of alcohol…**

****

**…and each of these is more than one unit**

****

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FAST** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 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 |  |
| Total |  |  |  |  |  |  |

**Lifestyle ……**

Please enter your height & weight:

|  |  |
| --- | --- |
| Height: | Weight: |

**Lifestyle exercise ……**

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

What exercise do you do?

How often do you exercise?

**Allergies ……**

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

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |
|  |  |

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

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication** | **Dosage** |
|  |  |
|  |  |
|  |  |

**Female patients only ……**

**vej**

Have you had a cervical smear test? 🞏 Yes 🞏 No If yes, what was the

result? (if known)

Date (if known)

**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 🞏

**Appendix 1**

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

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**Scan and send this page of form to:** [NHSDigital-EHIC@nhs.net](mailto:NHSDigital-EHIC@nhs.net)