Living Well Partnership

Health Status Form Age 15+

OFFICE USE ONLY:
RECEPTIONIST INITIAL: _____ **TODAY'S DATE:** _____ **PT ID NUMBER:** _____
IF PATIENT 40-74 YEARS BOOK HEALTH CHECK APPT **APPT BOOKED DATE:** _____ **TIME:** _____

Please complete **all** parts of the registration form and return to the surgery with **2** forms of ID (preferably one photographic ID such as passport or driving license and a utility bill) and a copy of your repeat prescription from your previous surgery.

Acceptable identification documents:

Name Identification

- Current signed full passport
- Current UK or current EU/EEA driving licence
- Current benefits or state pension notification letter confirming rights to benefits for the current period
- Current HMRC tax notification e.g. PAYE coding, statement of account (excluding P45s and P60s)
- Shotgun or firearms certificate
- Travel documents issued to foreign nationals granted permission to remain in the UK
- Residence permit issued by the Home Office to EU nationals
- EU/EEA member state identity card

Address Identification

- Recent utility bill/statement showing current address
- Local authority tax bill for current year
- Bank or building society statements
- Credit/store card statement
- Mortgage statement
- Local council rent card
- Tenancy agreement
- Solicitors letter confirming recent purchase of your property

Under 16s - Children under the age of 16 whose parent/guardian is registered with the practice or registering at the same time, will need to provide either and original birth certificate or a certified copy or passport

Have you been registered with this practice before? Yes No

Personal Details

Home Telephone:	Next of Kin:
Mobile Telephone:	Relationship:
Email:	Contact Telephone:
Marital Status:	Social Worker (if applicable):
Occupation:	Contact Telephone:
Main Language:	Do you require an interpreter? Yes No

Ethnicity:

- ☐ Asian or Asian British - Bangladeshi
- ☐ Asian or Asian British - Indian
- ☐ Asian or Asian British - Pakistani
- ☐ Asian or Asian British - other background
- ☐ Black or Black British - Caribbean
- ☐ Black or Black British - African
- ☐ Black or Black British - other background
- ☐ Chinese
- ☐ Mixed - White/Asian
- ☐ Mixed - White/Black African
- ☐ Mixed - White/Black Caribbean
- ☐ Mixed - any other mixed background
- ☐ White - British
- ☐ White - Irish
- ☐ White - any other white background
- ☐ Any Other _____

If you have any special communication needs, please speak to a receptionist so that we can record this in your notes

Signature:

Health Status

Height:	Weight:

☐Never Smoked ☐Current Smoker How many per day? _____ ☐Ex Smoker - when did you stop? _____

Smoking is a major contributor to ill health and greatly increases your risk of heart disease and lung disease. Smokers are advised that it is in their best interest to give up and may self refer to QUITTERS on telephone (023) 8051 5221

How many units of alcohol do you drink a week? _____units

A unit of alcohol is a small wine glass/1shot of spirit/1/2 pint beer or lager. It is better that the weekly allowance is spread evenly over the week rather than all in one night.

How would you describe your regular exercise level on a weekly basis?

☐ Inactive ☐ Light ☐ Moderate ☐ Rigorous

Aerobic exercise is brisk walking, jogging, swimming or cycling. A target level of 30 minutes of moderate aerobic activity (any activity that makes you feel warm and slightly out of breath) on at least 5 days a week is recommended.

Please indicate if you suffer from or have ever suffered from any of the following medical conditions:

☐ Diabetes	☐ Chronic Kidney Disease
☐ Epilepsy	☐ Strokes/TIAs
☐ Asthma	☐ COPD
☐ Thyroid Disorder	☐ Mental Health Problem
☐ Cancer	☐ Heart Disease
☐ Raised blood pressure	☐ Other _____

Do you have any family history we should be aware of? Please state condition, family member and age of onset

Do you have any allergies—please give details

Please list any regular medication, with the dose you are taking. Please attach a copy of your repeat prescription from your previous surgery.

Please list any serious illness or operations you have had with dates if possible.

Women Only

Have you ever had a cervical smear? Yes No

If yes:

When: _____ Result: _____ Next smear due: _____

If you think you are due a smear test, please speak to a receptionist who can book an appointment for you to have a smear test with one of our Practice Nurses

Are you currently pregnant? ☐ Yes ☐ No If yes, estimated date of delivery: _____

Carer Form

If you are a carer or are cared for, we would like to hold this information in your medical record. This will help us provide support as necessary and have a better understanding of your needs. You may be a carer even if you are a family member. By completing this form, you agree that we can retain this information in your medical record.

Please complete the following sections as appropriate:

I **am** a carer
I care for:
Address:
Contact Telephone:
Relationship (if any):
Is the person you care for registered at this practice? Yes / No

I **have** a carer
I am cared for by:
Address:
Contact Telephone:
Relationship (if any):
Is the person who cares for you registered at this practice? Yes / No
Are you registered disabled? Yes / No

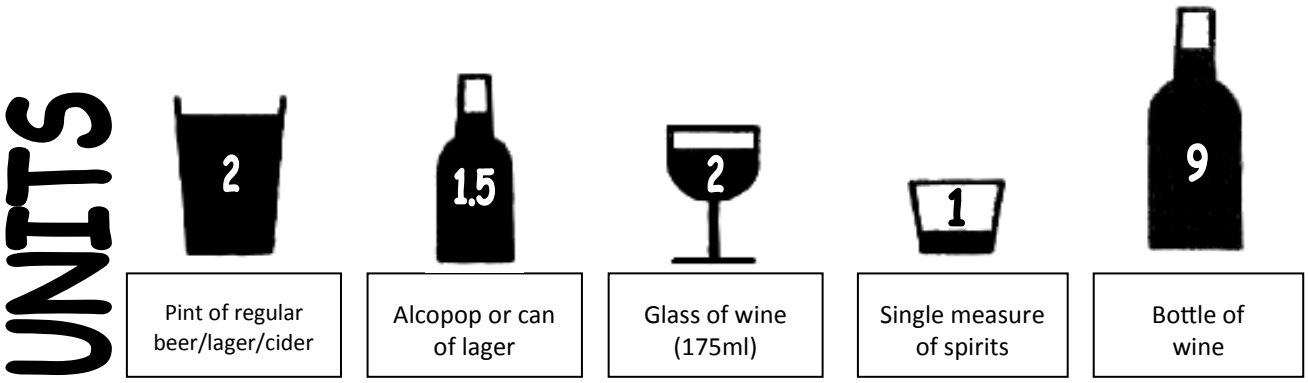
Consent

Text Messaging Appointment Reminder Service
You will be sent a text reminder 48 hours before your appointment
☐ Opt In ☐ Opt Out

Electronic Record Sharing
This is consent to have your data shared confidentially with other healthcare professionals (Hampshire Healthcare Record)
☐ Yes ☐ No

Care.Data (Health and Social Care Information Centre)		
The care.data programme was established by NHS England and the Health and Social Care Information Centre to securely bring together health and social care information from different healthcare settings, such as GP practices, hospitals and care homes.		
Dissent from secondary use of GP patient identifiable data	☐ Yes	☐ No
Dissent from disclosure of personal data by Health and Social Care Information Centre	☐ Yes	☐ No
Please ask at reception for an information leaflet		

Name: Date of Birth:



Fast Alcohol Screening Test (FAST)

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 OR LESS						
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/ 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	

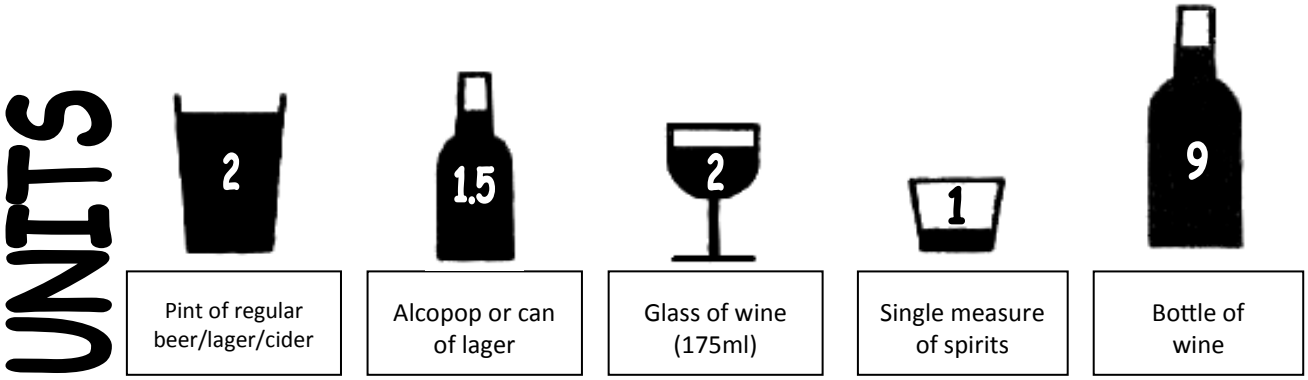
Scoring: A total of 3+ indicates hazardous or harmful drinking

Single Alcohol Screening Questionnaire (SASQ)

Men:	When was the last time you had more than 8 drinks in one day?			
Women:	When was the last time you had more than 6 drinks in one day?			
Select One:	Never	Over 12 months	3-12 months	Within 3 months

Scoring: Within 3 months indicates hazardous or harmful drinking

Name: Date of Birth:



Alcohol Users Disorders Identification Test (AUDIT)

	Scoring System					Your Score
	0	1	2	3	4	
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	
How often in the last year have you found you were not able to stop drinking once you had started?	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	
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	
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	
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	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/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: 0 – 7 = sensible drinking, 8 – 15 = hazardous drinking, 16 – 19 = harmful drinking and 20+ = possible dependence