Gosford Hill Medical Centre
167 Oxford Road
Kidlington
Oxford OX5 2NS
Tel 01865 374242
Fax 01865 377826

NEW PATIENT REGISTRATION QUESTIONNAIRE PART 1

complete in BLOCK CAPITALS

Surname: ______________________________ **Forename(s)** ________________________________

1	**Are you ordinarily resident in the UK?**	**Yes** ☐	**No** ☐
2	**Are you intending to reside in the UK for more than 6 months?**	**Yes** ☐	**No** ☐
3	**Are you intending to reside in the UK for 6 months or less?**	**Yes** ☐	**No** ☐
4	**Do you require medical treatment that will be covered by medical insurance?**	**Yes** ☐	**No** ☐
5	**Do you have a form E128?** The form E128 is used within the European Economic Area (EEA) and applies to workers or students (and their families who accompany them) who are posted from one member state to another. Patients with an E128 are entitled to full health care from the NHS	**Yes** ☐	**No** ☐
6	**Do you have a form E112?** The form E112 is used when a patient is referred to this country for treatment and is usually for hospital referrals. It may be used if the patient requires after-care before returning home.	**Yes** ☐	**No** ☐
7	**Are you a refugee** who has been given leave to remain in the UK	**Yes** ☐	**No** ☐
8	**Are you an Asylum Seeker**	**Yes** ☐	**No** ☐
9	**If you want to opt out** of the government centrally held record database and have your records held only in the surgery, answer 'yes'	**Yes** ☐	**No** ☐

I declare that the details above are correct.

Signed ____ Date __________________________

Please complete questionnaire part 2

Gosford Hill Medical Centre
167 Oxford Road
Kidlington.
Oxford OX5 2NS
Telephone 01865 374242 Fax 01865 377826

NEW PATIENT REGISTRATION QUESTIONNAIRE – PART 2
to be completed by all patients over the age of 12

Please complete this form and bring it with you to register. This information will help us to provide you with the best care until your full medical records are received. Please hand it to the Receptionist.

Title and Last Name		
First Name(s)		
Date of Birth	Male ☐	Female ☐
Address		
Home Tel No:	**Mobile Tel No:**	**Work Tel No:**
Contact in an Emergency	**Name:** **Tel No:**	**Relationship:**
Occupation		

Ethnicity

	Country of Origin	First Language
White		
White & Black Caribbean		
White & Black African		
White & Asian		
Asian or Asian British Indian/Pakistani/Bangladeshi/other		
Black or Black British		
Caribbean/African/other Black background		
Other ethnic group		

Carers Do you have significant (unpaid) caring responsibility for someone?	**Yes** ☐ **No** ☐ If yes please complete part 3 of this form

Please list any serious illnesses or accidents or operations you have had

Year **Illness/accident/operation** **Hospital**

Are you currently under medical care of any sort? **No** ☐ **Yes** ☐ If yes, please describe:

Do you suffer from any allergies? **No** ☐ **Yes** ☐ If yes, please describe:

Are you taking any regular medication? **Yes** ☐ **No** ☐

If yes, please describe

Height: **Weight:**

Date of last Tetanus injection:

Family History Questionnaire

Has anyone under 60 in your near family suffered from heart disease/angina or had a stroke?

No ☐ **Yes** ☐ PLEASE GIVE DETAILS

Has anyone under 60 in your near family suffered from diabetes/cancer/or other serious illnesses?

No ☐ **Yes** ☐ PLEASE GIVE DETAILS

Do you smoke? **YES** ☐ If yes, how many per day do you smoke?

No ☐ If given up please state when and how many per day did you smoke

Never Smoked ☐

Do you drink alcohol? NO ☐ YES ☐ Please complete below

Questions	**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 a month	2-3 times a week	4+ times a 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	

Scoring; A total of 5+ indicates hazardous or harmful drinking

FOR WOMEN

Have you had a cervical smear test? **Yes** ☐ **No** ☐

If yes please supply:

Date **Where Taken**

Result

Have you had a hysterectomy? **Yes** ☐ **No** ☐

If yes please supply date

Are you using any form of contraception? **Yes** ☐ **No** ☐

If yes please describe briefly

Thank you for completing this questionnaire, please bring this to the surgery together with your registration form, photo id and proof of residency within the practice boundary.

NEW PATIENT REGISTRATION QUESTIONNAIRE PART 3

CARERS IDENTIFICATION AND REFERRAL FORM

DO YOU LOOK AFTER SOMEONE WHO IS ILL, FRAIL, DISABLED OR MENTALLY ILL?

If so, you are a carer and we would like to support you.

Please complete this form and hand it in to reception.

If you are agreeable, we will pass your details to the Oxford Carers Centre, which is a local organisation providing a free, confidential service to carers in Oxford City. The centre provides advice, help and information on services in Oxford City for carers and disabled people, benefits, relief care, advocacy etc.

We will also refer you, with your permission, to have your needs assessed by Social and Health Care. A Carers Assessment is your legal right and a chance to talk about your needs as a carer and the possible ways help could be given. It also looks at the needs of the person you care for. This could be done separately, or together, depending on the situation. There is no charge for an assessment.

YOUR DETAILS

Name	
Date of Birth	
Address	
Post Code	
Telephone Number	
Any relevant information	

DETAILS OF THE PERSON YOU LOOK AFTER

Name	
Date of Birth	
Address (If Different from Above)	
Post Code	
Telephone Number (If different from above)	
GP Details (If different from your own)	

Please pass my details to the Oxford Carers Centre ☐

Please refer me to Social and Health Care for A Carers Assessment ☐