UNIVERSITY HEALTH SERVICE **CONFIDENTIAL MEDICAL REGISTRATION FORM** **HIGHFIELD HEALTH**

Please complete BOTH SIDES in FULL using BLACK and BLOCK CAPITALS

Have you registered at this practice before? Yes ☐ No ☐

NHS Number (if known)

Title
Mr ☐ / Miss ☐ / Mrs ☐ / Dr ☐ / Prof ☐ / Other……

Surname or family name

First name

Other forenames – Please give all remaining forenames

Previous surname (if married or have been known by another surname previously)
ONLY IF APPLICABLE

Date of birth (Day/Month/Year)
/ /

Gender
Male ☐ Female ☐

Southampton address

Post code

Mobile telephone (including full code)

May we use a text service to contact you in future? Yes ☐ No ☐

Home telephone (including area code)

Email

May we use email to contact you in future? Yes ☐ No ☐

University department

Date of expected departure from university/end of course (month/year)

Ethnic origin

Next of kin
Name:

Telephone:

If considered necessary by a healthcare professional, may we contact your next of kin? ☐ Yes ☐ No

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). Do you give your permission for us to upload data to:

Hampshire Health Record	☐ Yes	☐ No
Summary Care Record	☐ Yes	☐ No
Care.Data	☐ Yes	☐ No

WOMEN ONLY

Have you ever had a cervical smear test?

No ☐

Yes ☐
Please give details:

When:
Where:
Results: Normal / Abnormal
Next smear due date:

Please tick if you currently or have ever suffered any of the following problems:

	✓	Date diagnosed
Asthma (**only** if using inhalers **in the last year**)		
Diabetes (with or without insulin)		
Epilepsy		
Rheumatoid Arthritis or Osteoporosis		
Raised blood pressure		
Ischaemic heart disease/coronary heart disease		
Angina (heart, *NOT* throat related)		
Heart attack (myocardial infarction)		
Heart failure		
Atrial fibrillation (AF)		
Chronic kidney disease		
Schizophrenia		
Bipolar disorder		
Other psychotic illness		
Dementia (e.g. Alzheimer's disease)		
Stroke or mini-strokes (TIA's)		
Cancer		
Emphysema/Chronic bronchitis/COPD		

Do you smoke?
Never smoked ☐ Currently smoke ☐
Previously smoked ☐ → How many _____ per day

What is your height & weight?
Weight kgs st/lbs **Height** cms ft/in

What is your average alcohol consumption?
1 unit = ½ pint beer, lager or cider / 1 single measure spirit / 1 glass (125ml) wine
units/wk

Are you allergic to any medications?
No ☐ / Yes ☐ ⇨ Please state the drug and the reaction suffered, with a date if known

Are you taking any medication currently?
No ☐ / Yes ☐ ⇨ Please include contraception, creams or other items obtained on prescription

Do you have any other medical problems not listed above or have you ever been seen in a hospital or other clinic?
No ☐ / Yes ☐ ⇨ Please give details of what for, who and when

Have you ever had the following vaccinations?

	Yes Date given:	**No** Would you like to receive this immunisation?
Meningitis C	☐⇨ Date:	☐⇨ Yes ☐ No ☐
MMR or rubella	☐⇨ #1: Booster:	☐⇨ Yes ☐ No ☐
Tetanus	☐⇨ Last:	☐⇨ Yes ☐ No ☐

PRACTICE USE SCANNED [ ]

Please complete BOTH SIDES in FULL using BLACK and BLOCK CAPITALS

UNIVERSITY HEALTH SERVICE CONFIDENTIAL MEDICAL REGISTRATION FORM HIGHFIELD HEALTH

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FAMILY DOCTOR SERVICES REGISTRATION

The following information is required by the Health Authority to complete your registration.

Surname	
Forenames (in full please)	
Date of birth (Day/Month/Year)	☐☐ / ☐☐ / ☐☐☐☐
Your NHS number (if known)	☐☐☐ ☐☐☐ ☐☐☐☐
Your previous surname (if applicable)	
Town & country of birth	

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

Your previous address in the UK (e.g. home or parental address) **PLEASE INCLUDE THE POSTCODE**	
Name of previous doctor while at that address	Dr.
Address of previous doctor	

If you are from abroad

Your first UK address where registered with a GP	
If previously resident in the UK, date of leaving	
Date you first came to live in the UK	

If you are returning from the Armed Forces

Address before enlisting	
Enlistment date:	Service/personnel number:

Carer status

Are you the carer for someone with a disability or physical or mental care need?	☐ No ☐ Yes: Who?

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.
Please tick as appropriate:

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation: Date:

If you are registering a child under 5

☐ I wish the child named overleaf to be registered with the University Health Service for Child Health Surveillance

Please tick:
☐ Signature of patient
☐ Signature on behalf of the patient

Signature:	**Date:** (day/month/year)

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ALCOHOL, ANXIETY & DEPRESSION REFLECTIVE QUESTIONNAIRE

NAME	**DATE OF BIRTH**

Alcohol Scoring System

	Questions	0	1	2	3	4	Your score
AUDIT – C – 38D4 (5or more enter AUDIT score too)	How often do you have a drink containing alcohol	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
	How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
	How often have you have 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	
AUDIT – 38D3	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 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 needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	How often in the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
	How often in 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	
	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 suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
YOUR TOTAL ALCOHOL SCORE							

If your alcohol score above is 8 or more please answer the following sets of questions (for anxiety & depression):

Questions for **Anxiety** – over the **last 2 weeks** how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Your score
Feeling nervous, anxious or on edge	0	1	2	3	
Not being able to stop or control worrying	0	1	2	3	
Worrying too much about different things	0	1	2	3	
Trouble relaxing	0	1	2	3	
Being so restless that it is hard to sit still	0	1	2	3	
Becoming easily annoyed or irritable	0	1	2	3	
Feeling afraid as if something awful might happen	0	1	2	3	
YOUR TOTAL ANXIETY (GAD-7) SCORE					

Questions for **Depression** - over the **last 2 weeks** how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Your score
Little interest or pleasure in doing things	0	1	2	3	
Feeling down, depressed or hopeless	0	1	2	3	
Trouble falling or staying asleep or sleeping too much	0	1	2	3	
Feeling tired or having little energy	0	1	2	3	
Poor appetite or over eating	0	1	2	3	
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3	
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3	
Moving or speaking so slowly that othr people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3	
YOUR TOTAL DEPRESSION (PHQ-9) SCORE					

UNIVERSITY
HEALTH
SERVICE

ALCOHOL, ANXIETY AND DEPRESSION REFLECTIVE QUESTIONNAIRE – PATIENT GUIDANCE 2014

For many people, having a drink with friends is one of the pleasures of life. However, for others drinking may lead to a variety of problems. This is because they drink too much, too often.

We would like to ask you to complete a screening questionnaire when you register with the Practice to enable you to determine whether you are a sensible drinker, requiring no further action, or whether you could benefit from some simple, structured advice to promote "low risk" drinking.

We would ask that you complete the questionnaire overleaf and return it to the reception staff with your completed registration form.

If your alcohol score is 8 or more (classified as being as an increasing or higher risk level), evidence suggests that this COULD be related to a mental health issue (e.g. anxiety and/or depression), and we would ask that you complete the anxiety and depression questions too. This will help us assess if we can offer you any additional help.

Please note that when reflecting on your levels of alcohol consumption, please think about an "**average**" period of time, rather than the period of time when joining University, as experience tells us that many students increase their alcohol intake temporarily during the first few weeks at University!

Once completed, please return this form to the receptionist with your registration form – thank you!