NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✔ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

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

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ Signature of Patient ☐ Signature on behalf of patient Date_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

/

Family doctor services registration

GMS1

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

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

Signature confirming my agreement to organ/tissue donation **Date** _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date** _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

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DR. POOLO'S SURGERY
Rush Green Medical Centre

New Patient Registration

Personal Details

Title _____ First name _____ Surname _____

Date of Birth _____ Mobile/Telephone number _____

Would you be interested in joining our NHS Patient Participation Group?	Yes	☐	No	☐
Do you have a carer?	Yes	☐	No	☐
Are you a carer?	Yes	☐	No	☐

Summary Care Record

(Please read attached Summary Care Record leaflet for more information)

I express consent for medication, allergies and adverse reactions to be shared	☐
I express dissent that I do not want a Summary Care Record	☐

Ethnic Origin *(please circle)*

Asian/Bangladeshi		Black/ African	
Asian British	Indian	Black British	Caribbean
	Pakistani		
Mixed	White + Asian	White	British
	White + Black African		Irish
	White + Black Caribbean		Other Background
	Other (please state)	_____	

First language (please state) _____

Smoking Status (please circle)

Never smoked tobacco Ex-smoker Smoker

If you are a current smoker how many cigarettes do you smoke per day? _____

To improve your health we recommend that you stop smoking. If you are interested in giving up smoking please speak to a member of staff.

Medical Details

Height _____ Weight _____

Last blood pressure reading ___/___ Date ___/___/___

Next of kin _____ Next of kin contact number _____

Have you had your Meningitis C Vaccination? Yes ☐ No ☐ Date ___/___/___

Have you had your MMR Vaccine *(measles/mumps/rubella)*? Yes ☐ No ☐ Date ___/___/___

Women Only – Please give details of any pregnancies with dates

Date of last smear ___/___/___

Alcohol intake

How many units of alcohol do you drink per week? _____

1.6 units: One Glass of Wine (1.25ml)
2.3 units: One Glass of Wine (1.75ml)
1 unit – ½ pint beer/larger/1 pub measure of spirit

How often do you have 8 (men) / 6 (women) or more drinks on one occasion?

N/A ☐ Never (0) ☐ Less than Monthly (1) ☐ Monthly (2) ☐ Weekly (3) ☐ Daily or almost daily (4) ☐

ONLY ANSWER QUESTIONS 2, 3 & 4 IF YOUR ANSWER TO QUESTION 1 IS MONTHLY, WEEKLY OR DAILY

How often in the last year have you not been able to remember what happened when drinking the night before?

N/A ☐ Never (0) ☐ Less than Monthly (1) ☐ Monthly (2) ☐ Weekly (3) ☐ Daily or almost daily (4) ☐

How often in the last year have you failed to do what was expected of you because of drinking?

N/A ☐ Never (0) ☐ Less than Monthly (1) ☐ Monthly (2) ☐ Weekly (3) ☐ Daily or almost daily (4) ☐

Has a friend/relative/doctor/health worker been concerned about your drinking or advised you to cut down?

N/A ☐ No (0) ☐ Yes, but not in the last year (2) ☐ Yes, during the last year (4) ☐

Chronic conditions

Do you have any Chronic Conditions that you suffer from and their date of onset?

Asthma Yes ☐ No ☐ Date / /

Heart Yes ☐ No ☐ Date / /

Diabetes Yes ☐ No ☐ Date / /

Epilepsy Yes ☐ No ☐ Date / /

Other _____

If you do suffer from any chronic conditions how are you followed up?

With your GP or Practice nurse? Yes ☐ No ☐ At the Hospital? Yes ☐ No ☐

Please give us details of any allergies that you have to medication or other items (i.e. nuts, latex etc):

Family Medical History *Please give details of your family medical history. Tick the relevant boxes and say who the history relates to (only need for immediate family members. i.e. parents and siblings)*

Ischemic Heart Disease Yes ☐ No ☐ Family member _____ Age _____

CVA/Stroke Yes ☐ No ☐ Family member _____

Diabetes Yes ☐ No ☐ Family member _____

Asthma Yes ☐ No ☐ Family member _____

Signature _____ **Date** / /