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_____/_____/_____

Please see overleaf re: Organ donation

NHS

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

SHEPHALL HEALTH CENTRE
Ridlins End, Stevenage, Herts SG2 9QZ

NEW PATIENT HEALTH QUESTIONNAIRE

Thank you for your interest in registering with this general practice. Please complete both the form below and the GMS1 form.

Complete one of these registration forms for **EACH** new patient **over the age of 5 – there is a separate form for up to 5 year olds**. We ask that you complete all sections carefully and give as much information as possible. Your application to register may be delayed if they are returned incomplete.

Title (Mr/Mrs/Miss/Ms/other)	
Surname	
Forename	
Date of birth	
Sex (male/female)	
NHS number	
Address and postcode	
Mobile phone number	
Home telephone number	
Work telephone number	
Please contact us if your number changes	
Marital status	**Please circle one option:** Single/Married/Divorced/Widowed/ Separated/Co-habitating
Occupation	
Name of playschool, nursery, school or college	
Are you a Carer? If so please give details	
Details of previous GP	**Name:** **Address:**
Reason for leaving last surgery	
Have you been registered with us before?	
Please complete below if you are under 16	
Mother's full name **Contact telephone number**	
Father's full name **Contact telephone number**	
Guardian/foster carer full name **Contact telephone number**	

MEDICATION

Please list any repeat medication that you are currently taking including any repeat vaccinations. You will need to see the GP before your first prescription is issued.

Name of medicine	Strength and dosage information

ALLERGIES

Do you suffer from any allergies?

Please tick here if none
Please enter details here if you have allergies:

BRIEF MEDICAL HISTORY

Please supply a very **brief history of any major medical problems**, so that we have some record (in the event of you having to be seen by a doctor) before your notes arrive at the surgery. Please list any conditions that took you into hospital, any operations, and any important or continuing conditions.

FAMILY HISTORY

For all of the above conditions, please give details of any immediate family members (siblings, parents) who have suffered from the same condition.

LONG STANDING CONDITIONS

Do you suffer from any of the following? Please provide extra information where appropriate.

CONDITION	**YES**	**NO**
High blood pressure, hypertension		
Coronary heart disease, heart attacks, left ventricular function		
Underwent an operation to treat heart problems		
Stroke or transient ischemic attacks		
Asthma		
Chronic Obstructive Pulmonary Disease (COPD)		
Diabetes		
Epilepsy		
Hypothyroidism (please state if you suffer from any other thyroid problems)		
Cancer (not including non-melanotic skin cancers)		
Long-term mental health conditions		
Glaucoma, cataract or other eye problems		
Receiving Vitamin B12 injections		
Renal problems (had a transplant or are asplenetic)		

Height		**Weight**	

EXERCISE	**Please tick**
No exercise taken	
Little exercise less than three times a week	
Regular exercise at least three times a week	
What type of exercise do you undertake?	

DIET	**Please tick**
Diet not that healthy (could do better!)	
Healthy and varied diet including milk, meat, vegetables	
Vegetarian or vegan	
Other (give details)	
ALCOHOL (1 unit of alcohol = 1 pub measure of spirits OR half a pint of beer OR 1 glass of wine)	
How much alcohol on average do you drink in units each week?	

SMOKING Do you smoke? Please circle	Yes Please Circle; Cigarettes Pipe Cigars Other:	Ex-smoker Date that you quit:	Never smoked tobacco

The GPs at the practice strongly recommend that if you smoke, you take steps to give up smoking. Please request a stop smoking appointment with a nurse if you would like to stop.

For the NHS smoking helpline, call 0800 169 0 169

If you are pregnant and want to stop smoking, you can call 0800 169 9 169

For the local Hertfordshire Specialist Stop Smoking Service, call 0800 389 3 998

VACCINATIONS

If you have travelled abroad in the past 10 years or less and needed vaccinations, please provide details of the vaccinations you received and approximate dates. If you have a travel vaccination card, please bring this with you to your New Patient Check.

When was the last time you had a Tetanus injection?
Date of Meningitis C (Younger patients)
Date of Meningitis ACWY (Younger patients)
Have you had your BCG? If so, please give an approximate date
What date did you have your "school leavers" (Diphtheria, Tetanus and Polio) vaccination?

FEMALE PATIENTS

Date of most recent smear?	
Result of most recent smear?	
Have you had a hysterectomy?	
Have you ever had complications in pregnancy?	

SIGNED DECLARATION (MUST BE SIGNED)

I certify that the statements and facts made in this new patient questionnaire are true to the best of my knowledge.

1. All patients over the age of 15 must sign for themselves.
2. All patients under the age of 15 must be signed for by their parent or legal guardian.

Please tick the box on the right if you consent to being contacted from time to time via email and/or SMS text message with news about the practice ☐

Please tick the box on the right if you consent to being contacted from time to time via email and/or SMS text message with advice about your health and/or appointment reminders. We will be unable to send reminders unless you tick this box ☐

Signed: _____ Date: _____

Capacity: Patient / Legal Guardian (please indicate).

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare as some health problems are more common in certain communities. Telling us about your ethnic origins may help with the early identification of some of these conditions.

Choose ONE section from A to F, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background please specify below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please specify below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please specify below

D Black or Black British

	Caribbean
	African
	Any other black background please write below

E Chinese or other ethnic group

	Chinese
	Any other ethnicity? Please write below

F

	Do not wish to state

Spoken Languages: