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

Dr Westwood

Data Protection Act New patient Questionnaire– Appendix 1 to Annex M

Contact Details

Title ……..

Surname ……..

First Names ……

Previous Surnames ……..

Home Address

Postcode

Date of Birth ……

Home Tel ……

Mobile Number ……

Email Address ……

Profession/Occupation …….

Can we contact you by Text Message?
☐ Yes ☐ No

Can we contact you by email?
☐ Yes ☐ No

Information about you

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

Do you require an interpreter?
☐ Yes ☐ No

What is your main language……

Do you have any communication needs?
☐ Yes ☐ No

If yes, what are these needs?

☐ Braille ☐ Audio ☐ Other (please state)
☐ BSL ☐ Large Print

Height (approx.)

……ft…….in or ……..m

Weight (approx.)

…….st……lb or ……kg

Which of the following best describes how you think of yourself?

A: White
☐ British
☐ Irish
☐ Any other White background (Please Write in)

B: Mixed
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any Other mixed background (Please write in)

C: Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background (Please write in)

D: Black or Black British
☐ Caribbean
☐ African
☐ Any other Black background (Please write in)

E: Chinese or other Ethnic Group
☐ Chinese
☐ Any other (Please write in)

☐ Not stated

Which of the following best describes how you think of yourself?

☐ Woman (including trans woman)
☐ Man (including trans man)
☐ Non-binary
☐ In another way (please state)

……..

Is your gender identity the same as you were given at birth?

☐ Yes ☐ No

Which of the following best describes how you think of yourself?

☐ Lesbian / Gay
☐ Heterosexual/Straight
☐ Bisexual
☐ In another way (please state)

What is your employment status?
Please tick all options that apply

☐ Employed (full time)
☐ Employed (part time)
☐ Student (full time)
☐ Student (part time)
☐ Unemployed
☐ Retired

Are you are carer?
(A carer is *someone who provides unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support*)

☐ Yes ☐ No

If yes, who do you care for?

……...

Are you permanently housebound?

☐ Yes ☐ No
If you find it necessary to request a home visit we would be grateful if you could contact us before 10.30am

Have you ever served in the military?

☐ Yes ☐ No
If Yes which service?

Have you registered for Electronic Prescription Services (EPS)?

☐ Yes ☐ No

If yes which pharmacy have you nominated/would like to nominate?

……...

Please remember that you may need to update your nominated pharmacy if you are moving into the area. This can be done by visiting your pharmacy of choice.

Medication , Family History & Lifestyle

Do you take regular repeat medication?
☐ Yes ☐ No

If yes please attach a printout of your repeat medication from your previous GP Practice

Are you allergic to any medication?
☐ Yes ☐ No

Please state…….

Have you ever suffered from? (tick as appropriate)

☐ Epilepsy ☐ High Blood Pressure
☐ Cancer ☐ Heart attack/Stroke
☐ Asthma ☐ Mental Health
☐ COPD ☐ Diabetes
☐ Depression ☐ Blindness/Glaucoma
☐ Other ……
……
……

Do you have a family history of any of the following? If yes please detail family member(s) age and relation to you:

☐ Diabetes ……
☐ Epilepsy……
☐ Stroke…….
☐ Asthma……...
☐ Breast Cancer……...
☐ High Blood Pressure……
☐ Heart Disease……...

Have you had any significant operations?

☐ Yes ☐ No

Please give details:

Are you living with HIV?

☐ Yes ☐ No
☐ I don't know/unsure

Date of last cervical smear:

Do you enjoy?

☐ Heavy Exercise ☐ Light Exercise

☐ Moderate Exercise ☐ Exercise is impossible

What is your smoking status?

☐ Current smoker ☐ Ex-smoker

How many per day …….

☐ Never smoked

Your Data Matters to the NHS

Information about your health and care helps us to improve your individual care, speed up diagnosis, plan your local services and research new treatments.

In May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patient information safe and always being clear about how it is used.

You can choose whether your confidential patient information is used for research and planning

To find out more visit : **nhs.uk/your-nhs-data-matters** or call **0300 303 5678**

You can change your choice at any time

Online Services

Would you like to register for on line services so you can:

- ☐ Book & Cancel Appointments online
- ☐ Order Repeat Medication online
- ☐ View aspects of your medical record

Name: _____

Signature: _____

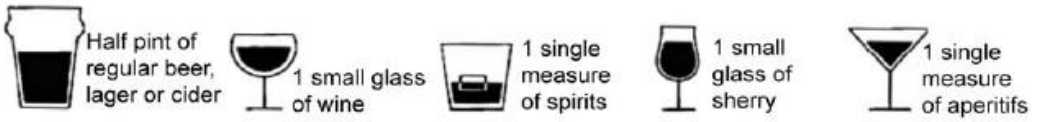
Date: _____

Creation date – 25th May 2018
Creator – Practice Manager
Deputy – Lead GP
Review – Two Yearly
Last Review – 31st January 2019

Please turn over to complete this questionnaire

AUDIT – C – Part One

This is one unit of alcohol…



…and each of these is more than one unit

How many units of alcohol do you consume in a week?……

Questions	Scoring system					Your score
	0	1	2	3	4	
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 - 9	10+	
How often have you had 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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

If your Audit C score is 5 or over please complete the next section

AUDIT – C – Part Two

Questions	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during 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 during 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 during 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 somebody 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 or friend, doctor or other 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Name: _____

Signature: _____

Date: _____

TOTAL Score equals
Score A (Previous Page) +
Score B (This page)