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

Family doctor services registration

GMS1

NHSOrgan 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**

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

NHSBlood 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 CHSlist 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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RALEIGH SURGERY

PATIENT MEDICAL HISTORY FORM

Please complete ALL sections 1-6 of this form, then sign and date it. Please hand it to a receptionist with your registration form. The information will be treated as strictly confidential, but it will be of great assistance to your doctor. THANK YOU.

1

SURNAME		TITLE (Mr, Mrs etc)	
FORENAME		MARITAL STATUS	
DATE OF BIRTH		HOME PHONE	
EMAIL		MOBILE PHONE	

2

NEXT OF KIN (Relationship e.g. father, sister etc)	
TITLE (Mr/Mrs etc)	
FULL NAME	
ADDRESS	
CONTACT TELEPHONE NUMBER	

3

ETHNIC ORIGIN	[please tick ✓ ONE sub-group that applies to you]	BRITISH ☐	IRISH ☐
OTHER WHITE ☐	WHITE & BLACK CARIBBEAN ☐	WHITE & BLACK AFRICAN ☐	INDIAN ☐
PAKISTANI ☐	ANY OTHER ASIAN BACKGROUND ☐	BANGLADESHI ☐	CARIBBEAN ☐
AFRICAN ☐	OTHER BLACK BACKGROUND ☐	CHINESE ☐	OTHER ETHNIC GROUP ☐
MAIN LANGUAGE SPOKEN	*Please specify*		

4

Do you suffer any of the following conditions [please tick ✓where appropriate]

CORONARY HEART DISEASE ☐	DIABETES ☐	EPILEPSY ☐	ASTHMA ☐
CHRONIC OBSTRUCTIVE DISEASE ☐	STROKE ☐	MENTAL HEALTH ☐	HYPERTENSION ☐
NONE OF THE ABOVE ☐		PLEASE LIST ANY DISABILITIES	
ARE YOU A CARER FOR SOMEONE? ☐	*Who do you care for? (e.g. husband, daughter)*	ARE YOU CARED FOR BY SOMEONE? ☐	*If yes, who cares for you*

5

Do You Smoke & Drink? [please tick ✓where appropriate]

SMOKING Would you like our smoking advisor to contact you? ☐	NEVER SMOKED ☐	SMOKER - CIGARETTES PER DAY ☐	EX SMOKER ☐
ALCOHOL	I AM A NON DRINKER OF ALCOHOL ☐	I DRINK ALCOHOL - UNITS PER WEEK	☐ UNITS PER WEEK 1 pt beer = 3 units, 1 glass wine = 2.5 units

Please advise us of the following	
Occupation:	
HEIGHT :	**WEIGHT:**

6

Medication that you are currently taking. Please indicate below your medication.	
Are you allergic to any medication? [please tick ✓as appropriate]	Yes ☐ No ☐
Medication:	Reaction:
Medication:	Reaction:
Medication:	Reaction:

7

Family Medical History [please indicate members of your family with these conditions]	
Condition	Please state family member with this condition
Angina [below age 60]	
Angina [above age 80]	
Heart attack [below age 50 - men]	
Heart attack [below age 60 - women]	
Heart attack [above age 60]	
Cancer of the bowel	
Cancer of the breast	
Diabetes	
Glaucoma	
Hypercholestrolaemia (high blood fat)	
Hypertension (high blood pressure)	
Stroke	

8

Have you ever served in the Armed Forces?	Yes ☐

Your Signature

Today's Date:

Thank you for taking the time and trouble to complete this form. It will greatly assist in creating an accurate picture of your details and medical needs.