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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1.6km 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_____/_____/_____

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

Signature confirming my consent to join the NHS Organ Donor Register **Date** _____/_____/_____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register **Date** _____/_____/_____

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

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

052019_006 Product Code: **GMS1**

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date _____/_____/_____

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** ☐ **NO:** ☐	If yes, please enter details from your EHIC or PRC below:	
	Country Code:		
	3: Name		
	4: Given Names		
	5: Date of Birth	DD MM YYYY	
	6: Personal Identification Number		
	7: Identification number of the institution		
	8: Identification number of the card		
	9: Expiry Date	DD MM YYYY	
PRC validity period (a) From:	DD MM YYYY	(b) To:	DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Millway Medical Practice FAMILY DOCTOR REGISTRATION SERVICES
ADULT

Dear patient

By answering the question on this form you will be helping us to deliver better services to you as an individual. It is hoped that this will give us a better picture of the local population, which will help in planning new service.
es and changing existing ones.

We encourage all patients to complete this form fully. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breech the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning. 07973794845

If you need any help to fill in this form, or have any queries regarding this form, please feel free to ask the reception team.

Thank you for your help.

Mr □ Mrs □ Miss □ Ms □ Other □ **Male □ Female □**

Surname _____ **DOB_____/____/_____**

First Name(s) _____

Previous Surname_____ **NHS Number _____**

Home Address

_____

_____

Town and Country of Birth _____

Telephone Number: 020 _____ **Mobile Number _____**

Work Telephone Number: _____

E-mail Address *(this will only be used for surgery correspondence*_____

Are you housebound? Yes □ No □

Name of Next of Kin_____ **Contact Number_____**

Relationship to the person _____

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

Previous Address in the UK

_____

_____

Name and Address of your previous doctor

_____

_____

If you are from abroad

Your first UK address where registered with a GP

_____

Date you entered the UK _____

Employment Status
Please tick

Retired □ Student □ Unable to work □ Unemployed □ Employed as _____

If you have children of your own aged 16 years or under, please list their names and dates of birth below?

Names	Date of birth

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:**_____

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 my agreement to organ/tissue donation:

_____ **Date:**_____

Are you a carer?

i.e. Do you look after a friend or a relative who is sick, disabled, elderly has a mental heath problem or for any other reason?

Yes □ No □

Are you cared for?

i.e. Do you have a friend or relative who helps you live your day to day life?

Yes □ No □

If yes please give details of your carer's contact information:

Name _____

Contact Number: _____

Ethnic Status, Nationality & Language

What is your country of birth?

What is your main spoken language?

What language do you prefer to read?

What do you consider to be your national identity?

Do you need an interpreter or translator?

Please tell us your ethnic group by ticking the box

White British □
White Irish □
White Scottish □
White Welsh □

Asian or Asian British □
Bangladeshi □
Indian □
Pakistani □

Mixed Background □
White & Asian □
White & Black African □
White & Black Caribbean □

Black or Black British □
African □
Caribbean □

Chinese □
Vietnamese □

Any other background please write. _____

Women's Health
(This next section is for women only)

Cervical Smears

Date Taken	At GP / Clinic	Results	Recall Date

Contraception
If you are using any form of contraception please list in the box below.
(Please give LARC leaflet if OCP is listed)

Have you been screened for:

Chlamydia Yes / No If yes please tell us the date:
Breast Screening Yes / No If yes please tell us the date:

Vaccinations

Influenza	Date Given
Pneumonia	Date Given
Shingles	Date Given

Personal Habits (all to complete)

Smoking, Alcohol & Exercise
Please tick which applies to you
Smoking

Never Smoked □ Non-Smoker □ Pipe □ Cigars □ Rolling Tobacco □
Current Smoker □ (if so how many per day) _____ Would you like us to help you stop yes/no
Ex-smoker □ (if so how many did you smoke per day) _____ and the date you stopped _____

Alcohol Screening

Based on 1 unit = ½ pint of beer or 1 glass of wine (125 ml) or 1 single spirits

Questions	**Scoring System** 0	1	2	3	4	**Your Score**
How often did you drink alcohol in past year	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
Only answer the following questions if your score is above 1.						
How many standard alcoholic drinks do you have on a typical day when drinking	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often in the last year have you failed to do what was expected of you because of drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested you cut down?	**No**		**Yes, on one occasion**		**Yes, on more than one occasion**	
Total Score	**Add up your total score and enter it in the box on the right ⇒** **If you score 3 or more, please complete the next questionnaire**					

Alcohol Screening Part 2 – only complete if your score was 3 or more in the questionnaire above.

Questions PART 2	Scoring System 0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when drinking	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in 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 in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/ friend/ doctor/ health worker been concerned about your drinking or advised you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
Total Score	**Add up your total score and enter it in the box on the right ⟹** **Scoring 8-15 = hazardous drinking, 15-19 = harmful drinking, 20 or more = possible dependence**					

Measurements
Please can you fill in the below values to the best of your knowledge:

Height : _____ kg
Weight : _____ kg

If you have a blood pressure machine at home or access to a blood pressure machine please fill in the below:
BP READING /
PULSE RATE

Exercise

Do you exercise regularly? Yes/No

If yes,

a) how often do you usually exercise?
less than once a week ☐ up to three times a week ☐ up to 5 times a week ☐ more than 5 times a week ☐

b) how long does your exercise usually last?
less than 10 minutes each time ☐ less than 30 minutes each time ☐ 30 minutes or more each time ☐

Do you suffer from any of these conditions?

	Approximately when diagnosed / Year
Diabetes	Yes / No
High Blood Pressure	Yes / No
Stroke	Yes / No
Osteoporosis	Yes / No
If Yes have you ever had a Dexa Scan?	Yes / No
Epilepsy	Yes / No
Asthma	Yes / No
Allergies or Hay fever	Yes / No
Eczema	Yes / No
Depression and/or Anxiety	Yes / No
Cancer	Yes / No

If yes, please state which type eg. Breast, colon, lung

Please detail any other conditions you suffer from that are not mentioned above:

Are you taking any medication? **If so, please tell us what you are taking**:

Name of medication	**Dose of medication**

Have you had any operations in the past? If so, please give details in the space below.

Have you had any vaccines in the last 10 years? If so, please list, please include seasonal flu vaccine.

Do you have any allergies?

Medication	Food	Anything Else

Have you had an NHS Health Check in the past year **Yes / No**

Have you been screened for HIV **Yes / No**

Family History

Please let us know in this section of any illness that is in your family:

Disease	**Relative**
Heart Disease	
Stroke	
Hypertension	
Diabetes Type 1 or Type 2	
Asthma	
Cancer	
Any other	

PLEASE CIRCLE YOUR ANSWER AS APPROPREATE

Do you give your consent to have your medical records shared on the National Data Base? **Yes / No**

Do we have your consent to use your email address for referral or medical contact? **Yes / No**

Do we have your consent to contact you by text? **Yes / No**

Would you like to have access to your medical records on-line? **Yes / No**

Would you like to be set-up to book appointments on-line? **Yes / No**

Would you like to be able to book your repeat prescriptions on-line? **Yes / No**

If you have answered yes to any of the above 3 questions, the surgery will contact you with your login details within 21 days.

Thank you for taking time to complete this form.
Please ask at reception for a practice leaflet to explain the services we offer at our Practice

SIGNED: _____

DATE: _____

STAFF ONLY
PATIENT'S EMIS NUMBER:

HEIGHT WEIGHT BMI

BP READING /

NP INFORMATION ENTERED ON SCREEN BY:_____

REGISTRATION FORM ENTERED ON SCREEN BY:_____

DATE ENTERED ON SCREEN_____
USUAL GP _____