The Spinney Medical Centre

Meeting Everyone's Health Needs

All information given will be treated in the strictest confidence

Name _____ **D.O.B.**_____

Address:_____

_____ **Postcode:**_____

Preferred contact telephone number _____ **Mobile number** _____

If you suffer from any of the following please tick box

Asthma	☐	**Epilepsy**	☐
COPD	☐	**Thyroid Disease**	☐
Diabetes	☐	**Cancer**	☐
Stroke	☐	**Mental Health Problems**	☐
Heart Disease	☐	**High Blood Pressure**	☐
High Cholesterol	☐	**Other please state:** _____	

Do you have a disability? ☐ **Yes** ☐ **No**
Are you a Carer? ☐ **Yes** ☐ **No**

Please Enter Your Smoking Status ☐ **Never Smoked** ☐ **Ex smoker** ☐ **Year stopped** _____
☐ **Current Smoker**

If you are a **Current Smoker** and would like help in quitting – please tick this box ☐ so that the Practice Nurse will know to speak to you about this at your New Patient Medical.

Alcohol Intake: How often do you have a drink containing Alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times / Month
☐ 2-3 times / Week ☐ 4 + time / Week

How many Standard drinks containing Alcohol do you have on a typical Day?

☐ None ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6
☐ 7 to 9 ☐ 10 or more

How often do you have six or more drink on one occasion?

☐ Never ☐ Less than Monthly ☐ Monthly
☐ Weekly ☐ Daily or almost Daily

Female patients only:

☐ **Have you had a Hysterectomy?** ☐ **Have you had a cervical smear in the last 5 years**
If no please arrange a convenient appointment

CHILDREN UNDER THE AGE OF FIVE:

If your child is 5 or under, please bring RED book which gives details of your child's immunisation status the details of which we can enter onto our computer system to ensure we have up-to-date details of their vaccination schedule.

DO YOU TAKE ANY REGULAR MEDICATION YES/NO If yes please list overleaf or attach printout from previous GP

ETHNIC GROUP

What is your Ethnic Group? Choose ONE section only

White

☐ British ☐ Irish ☐ Any Other White background (please state) _____

Mixed

☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please state) _____

Asian or Asian British

☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please state) _____

Black or Black British ☐ Caribbean ☐ Africa
☐ Any other Black background (please state)_____

Any Other Ethnic Group ☐ Chinese ☐ Vietnamese ☐ Any Other (please state)_____

☐ **Do not wish to state**

What is Your Preferred Language (Please choose ONE)

	Spoken	**Written**
English	☐	☐
Vietnamese	☐	☐
Chinese	☐	☐
Hindi	☐	☐
Punjabi	☐	☐
Urdu	☐	☐
Cantonese	☐	☐
British Sign Language	☐	☐

Other (please state) _____

What is your Religion (tick one box only)

☐ None	☐ Church of England	☐ Roman Catholic
☐ Christian	☐ Buddhist	☐ Hindu
☐ Jewish	☐ Islam	☐ Jehovah's Witness
☐ Other (please state) …….		
☐ Do not wish to state		

Please inform us IMMEDIATELY of any change of Address or Telephone Numbers

THANK YOU FOR COMPLETING THIS FORM

Dr Van Dessel, Dr Cox, Dr Hyde & Dr Clarke

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 d d m m y y

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Ethnic Origin

First Language

Home address

Postcode

Telephone No:

Mobile No:

Are you a carer? ☐

Do you have a carer? ☐

Are you registered Disabled? ☐

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

Date Left

If you are registering a child under five.

☐ 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*

☐ 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

** Not all doctors are authorised to dispense medicines.*

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date

Version 01/02

Please see overleaf re: Organ donation

NHS

Family doctor services registration

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 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 0845 60 60 400

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 three 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 the 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

Practice Stamp

Name Date

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