Please complete all pages in full using block capitals

1. Background Details

Contact Details

Name		Gender	
Address		Date of Birth	
		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Parent / Guardian	Name:	Tel:	Relationship:

** It is your responsibility to keep us updated with any changes to your telephone number, email & postal address.*

We may contact you with appointment details, test results or health campaigns or Patient Participation Group details.

If you do not consent to being contacted by SMS or email, please tick here: ☐ SMS ☐ Email

Other Details

Previous GP	Name:		Address:	
Country of Birth				
Ethnicity	☐ White (UK)	☐ Black Caribbean	☐ Bangladeshi	☐ Arabic
	☐ White (Irish)	☐ Black African	☐ Indian	☐ Chinese
	☐ White (Other)	☐ Black Other	☐ Pakistani	☐ Other
Religion	☐ C of E	☐ Buddhist	☐ Sikh	☐ No religion
	☐ Catholic	☐ Hindu	☐ Jewish	☐ Other:
	☐ Other Christian	☐ Muslim	☐ Jehovah's	
Housing	☐ Own House	☐ Nursing Home	☐ Homeless	☐ Asylum Seeker
	☐ Rented House	☐ Residential Home	☐ Housebound	☐ Refugee
	☐ Shared House	☐ Sheltered		
Employment	☐ Employed	☐ Self-employed	☐ House husband	☐ Retired
	☐ Student	☐ Unemployed	☐ Carer	☐ International Student
	☐ House wife			
Overseas Visitor	☐ Yes	☐ European Health Insurance Card Held		
Armed Forces	☐ Military Veteran	☐ Family Member		

Communication Needs

Language	What is your main spoken language?			
	Do you need an interpreter?		☐ Yes	☐ No
Communication	Do you have any communication needs?		☐ Yes	☐ No (if **yes** please specify below)
	☐ Hearing Aid	☐ Large print	☐ British Sign Language	
	☐ Lip reading	☐ Braille	☐ Makaton Sign Language	☐ Guide dog

Carer Details

Are you a carer?	☐ Yes - informal/unpaid carer	☐ Yes - Occupational/paid carer	☐ No
Do you **have** a carer?	☐ Yes Name*:	Tel:	Relationship:

**Only add carer's details if they give their consent to have these details stored on your medical record*

2. Medical History

Medical History

Have you suffered from any of the following conditions?

☐ Asthma	☐ Heart Disease	☐ Diabetes	☐ Depression
☐ COPD	☐ Heart Failure	☐ Kidney Disease	☐ Underactive Thyroid
☐ Epilepsy	☐ High Blood Pressure	☐ Stroke	☐ Cancer - Type:

Any other conditions, operations or hospital admission details:

If you are currently under the care of a Hospital or Consultant outside out area, please tell us here:

Family History

Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

☐ Asthma	☐ Heart Disease	☐ Diabetes	☐ Depression
☐ COPD	☐ Stroke	☐ Kidney Disease	☐ Thyroid
☐ Epilepsy	☐ Blood Pressure	☐ Liver Disease	☐ Cancer

Other:

Allergies

Please record any allergies or sensitivities below

Current Medication

Please check and include as much information about your current medication below

Please give us your previous repeat medication list if possible

3. Your Lifestyle

Alcohol

Please answer the following questions which are validated as screening tools for alcohol use:

AUDIT 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?	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	
					TOTAL:	

A score of **less than 5** indicates lower risk drinking

Scores of 5 or more requires the following 7 questions to be completed:

AUDIT QUESTIONS (after completing the above 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	
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?	Never		Not in the last year		Yes, during last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	Never		Yes, but not in last year		Yes, during last year	
					TOTAL:	

3. Your Lifestyle - continued

Smoking					
Do you smoke?	☐ Never smoked	☐ Ex-smoker		☐ Yes	
Do you use an e-cigarette?	☐ No	☐ Ex-User		☐ Yes	
How many did/do you smoke a day?	☐ Less than one	☐ 1-9	☐ 10-19	☐ 20-39	☐ 40+
Would you like help to quit smoking?	☐ Yes	☐ No			
	For further information, please see: www.nhs.uk/smokefree				

Height and Weight	
Height	
Weight	

Women Only			
Do you use any contraception?	☐ Yes	☐ No	If needed, please book appointment
Are you currently pregnant or think you may be?	☐ Yes	☐ No	Expected due date:

Students Only			
Students are at risk of certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression Please see www.nhs.uk/Livewell/Studenthealth			
I am less than 24 years old and have had two doses of the MMR Vaccination	☐ Yes	☐ No	☐ Unsure
I am less than 24 years old and have had a Meningitis C Vaccination	☐ Yes	☐ No	☐ Unsure

British Armed Forces		
Have you ever served in the British Armed Forces??	☐ Yes	☐ No

4. Further Details

Electronic Prescribing	
If you would like your prescriptions to go electronically, please provide details of the pharmacy you would like to use	Pharmacy:

Patient Participation Group		
Would you like to be involved in our Patient Participation Group?	☐ Yes	☐ No

We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.

Organ Donation	
Blood Donation	☐ I am already a blood donor ☐ I wish to be a blood donor ☐ I do not wish to be a blood donor
Organ Donation	☐ I am already registered as a donor ☐ I wish to be a donor - all body parts ☐ I wish to be a donor - for these body parts: ☐ I do not wish to be a donor To register: Online: www.blood.co.uk/the-donation-process/recognising-donors Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card

Signature	
Signature	I confirm that the information I have provided is true to the best of my knowledge ☐ Signed on behalf of the patient
Name	
Date	

Checklist

Please ensure the following are done and provided so that your registration can be completed successfully

- ☐ Completed and signed above form
- ☐ Completed and signed GMS1 Form
- ☐ Photo Proof of ID e.g. Passport, Photo Driving License or Photo ID Card
- ☐ Proof of Address

Practice Use Only

Appointment	☐ Required	☐ Not Required		
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Council Tax	☐ Bank Statement	☐ Other
GP Code				

5. Sharing Your Health Record

Your Health Record

Do you consent to your GP Practice sharing your health record with other organisations who care for you?

☐ Yes *(recommended option)*
☐ No

Do you consent to your GP Practice viewing your health record from other organisations that care for you?

☐ Yes *(recommended option)*
☐ No

Your Summary Care Record (SCR)

Do you consent to having an Enhanced Summary Care Record with Additional Information?

☐ Yes *(recommended option)*
☐ No

Signature

Signature	☐ Signed on behalf of the patient
Name	
Date	