NHS Family doctor services registration **GMS1** Office use only: *Emis No.*

(PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS)

[*A*]

☐ ☐ ☐ ☐ ☐

Mr Mrs Miss Ms Mx Surname

(Please circle)

Full first & middle names

Date of birth **Previous Name(s) (If any)**

NHS Number (if known) ☐ ☐ **Male / Female (Please tick)**

Mobile/Home tel…….... **Town and country of birth:** .....

Home Address

……..

……

…….. Postcode ……

E-mail address:

[B] **Previous home address where registered with your last doctor**

……

……..Postcode……

Name and Address of Previous Surgery

……...

[C] **If you are from or returning from abroad**

Date you first came to live in UK:

If previously resident in UK: date of leaving:

[D} **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:

Service or personnel number:……..Enlistment date **Discharge date**

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

Signature of patient **Signature on behalf of patient**

Typing your name will be counted as a signature

I give my permission for Farnham Park Health Group to contact me by: phone☐ TEXT☐ or email ☐

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

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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 your home address, 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

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. Please select and indicate your ethnic origin below. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

(***Please tick or circle)***

A. White
- ☐ British
- ☐ Irish
- ☐ Any other white background

B. Mixed
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background

C. Asian or Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background

D .Black or Black British
- ☐ Caribbean
- ☐ African
- ☐ Any other black background

E. Chinese or other ethnic group
- ☐ Chinese
- ☐ Other

The Fast Alcohol Screening Test (FAST)

Name:	**Date of birth:**

Please indicate your alcohol consumption. This is not compulsory but may help with your healthcare.

The Fast Alcohol Screening Test (FAST)

Questions	**Scoring Scheme**					**Enter score below:**
	0	1	2	3	4	
1. How often do you have 8 or more drinks (for a man) / 6 or more drinks (for a woman) on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only consider Questions 2, 3 and 4 if the response to Question 1 is monthly or more frequently than monthly						
2. 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	
3. How often during the last year have you failed to do what is expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. In the last year has a relative or friend, or a doctor or health worker, been concerned about your drinking or suggested that you cut down?	No		Yes, on one occasion		Yes, on more than one occasion	
					Total:	

Alcohol consumption screening test declined ☐

Would you like to access your medical record online? Please tick. ☐
The practice will contact you.

Action for Carers. Are you looking after a friend or relative who couldn't manage without you? Please tick. The practice will contact you. ☐

Free local support available to you

~~One You Surrey~~ is a specialist stop smoking service, commissioned by Surrey Public Health. At this current time, their service is over the phone or via video call. Using their service means you are 3 times more likely to successfully quit than if you were to quit alone.

You are eligible for:

- Specialist behavioural support
- Nicotine replacement or stop smoking medication
- Your own friendly specialist stop-smoking practitioner
- A personalised quit plan
- Flexible appointment days and times

Sign-up free to your local stop smoking service by

: Calling: 01737 652168 (Mon-Friday 9am-5pm)
Visiting: www.oneyousurrey.org.uk & click the 'get started' button at the top right.

(office use only)

Medical History and Lifestyle Questionnaire

Emis No.

Full Name:	**Date of Birth**:

Do you have any current medical conditions? ☐ **(NO)**
(for example asthma or diabetes) ☐ **(YES) (please state)**

_____

_____

Have you had major illnesses in the past?

_____

_____

Have you had any operations in the past?

Please list any medication you are taking

Do you have any allergies? ☐ **(NO)** ☐ **(YES)** (please indicate)

Lifestyle Check –

Smoking

Do you smoke? ☐ **YES** ☐ **NO** If YES, how many cigarettes a day? _____

If NO have you ever smoked? ☐ **YES** ☐ **NO**

If YES, how many cigarettes a day?
_____
When did you stop?
_____

Drinking

How many units of alcohol do you drink in an average week? _____

Exercise: Heart rate raised due to physical exercise; football/ running/ gym etc

0/wk ☐ 1/wk ☐ 2/wk ☐ 3+/wk ☐

Family History – Please indicate which member of the family. (Mother, Father, Brothers, Sisters Only)

Cancer (which?)…….. Diabetes …….. type 1 ☐ type 2 ☐

Asthma……. Heart Attack/Angina …under 60 ☐ over 60 ☐

Hypothyroidism (under active Thyroid) ……. CVA/Stroke…….

BELOW TO BE COMPLETED BY THE GP PRACTICE

PRACTICE NAME: Farnham Park Health Group

PRACTICE CODE:

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

☐ 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

Name: Date:

Authorised Signature