

# Beech House Surgery

## New Patient Registration Form

Welcome to Beech House Surgery!

For Office Use:  
Reception: \_\_\_\_\_  
Data: \_\_\_\_\_  
5/11

Please complete the details below in full and the Family Doctor Services Registration Form GMS1 and return both to the reception staff so that we can register you.

SURNAME:		Mr/Mrs/Ms/Miss		FORENAME(S)	
ADDRESS:				POST CODE:	
PHONE:			MOBILE:		
<i>We may like to contact you by text with appointment reminders and other information. Please indicate if you are willing to be contacted in this way.</i>					
DATE OF BIRTH:		SEX: (M/F)		HEIGHT:(cms):	
				WEIGHT:(kgs)	
NEXT OF KIN (name & contact info)				EMAIL:	
<i>We would like to contact you by email from time to time with information and occasional questionnaires about your experience of our services. Please indicate if you are willing to be contacted in this way</i>					
<b>Ethnicity: Please tick the one that applies to you</b>					
White British		White & Black Caribbean		Asian Indian	
White Irish		White & Black African		Asian Pakistani	
White Other		Other Mixed Background		Asian Bangladeshi	
Chinese		Other Asian		Other Ethnic Group	
<b>Language: Please indicate what you consider to be your first language?</b>			<b>Alcohol Consumption</b>		
English: Yes/No:				Wine	Number of glasses per week
Other Language —Please Indicate:				Beer	Number of pints per week
If English is not your first language, do you speak English?—Yes/No				Spirits	Number of singles per week
<b>What is your current smoking status?</b>			How often do you drink Alcohol?	A. Never B. Monthly or less C. 2-4 times per month D. 2-3 times per week E. 4 or more times per week	O O O O O
Never Smoked				How many standard drinks containing alcohol do you have on a typical day?	A. 1 or 2 B. 3 or 4 C. 5 or 6 D. 7 to 9 E. 10 or more
Passive Smoker				How often do you have six or more drinks on one occasion?	A. Never B. Less than Monthly C. Monthly D. Weekly E. Daily or almost Daily
Ex-Smoker		When did you give up?			
Current Cigarette Smoker		Number per Day?			
Current Pipe Smoker		Ounces per Week?			
Current Cigar Smoker		Number per Day?			
Are you interested in stopping? Yes or No? - if 'Yes' we will arrange for you to see our smoking cessation advisers					
Do you want to be an organ donor? Yes or No? If Yes please complete the reverse of the purple GMS1 form.			Do you want to be a blood donor? Yes or No? If Yes please complete the reverse of the purple GMS1 form.		
<b>Do you take regular exercise? - please tick one that applies to you</b>					
Exercise is physically impossible			I enjoy moderate exercise		
I avoid even trivial exercise			I enjoy heavy exercise		
I enjoy light exercise			I am a competitive athlete		

<b>Clinical Review:</b> Please answer the following questions:	YES/NO	
Are you taking any regular (daily/weekly etc.) medication? ( <i>Attach a copy of your current prescription if you can</i> ).	Details:	
Have you had a tetanus booster vaccination?		Date (mm/yy):
Have you ever had a rubella vaccination?		Date (mm/yy):
<i>Ladies:</i>		
Have you had a cervical smear test?		Date (mm/yy):
Have you had a hysterectomy?		Date (mm/yy):
Are you adopted?		
Is there a family history of Heart Disease?		Which Relative?
		Age of Relative * < 60 > 60
Is there a family history of CVA/Stroke?		Which Relative?
Is there a family history of Diabetes?		Which Relative?
Is there a family history of Glaucoma?		Which Relative?
Do you suffer from Diabetes Mellitus?		* delete as applicable
Do you suffer from Ischaemic Heart Disease		
Do you suffer from high blood pressure?		
Do you suffer from Stroke/CVA?		
Do you suffer from Asthma?		
Do you suffer from Chronic Obstructive Pulmonary Disease?		
Do you suffer from any other long-term illness?	Details:	
Do you suffer from Allergies?	Details:	
Is there any other clinical information about yourself that you consider relevant?	Details:	

### Summary Care Record (SCR)

Have you opted out of having a Summary Care Record on the national NHS database? (YES/NO)	
If you have not opted out, are you happy to have a Summary Care Record to be created? If you are unsure please see the attached SCR leaflet for more information. If you do not want to have an Summary Care Record, please complete the disclaimer on the form and return to the surgery.	

### Carers

Are you a carer? (YES/NO)		Do you have a carer? (YES/NO)	
Carer's Name and Address:			
If you are a carer or have a carer, some additional services may be available to support you. Please call Carers' Resource on 01423 500555			

<b>Signed:</b>	<b>Date:</b>
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