NHS Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick as appropriate

☐Mr ☐Mrs ☐Miss ☐Ms ☐ Mx ☐ Other……

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐Female ☐ Other……

Town and country of birth

London 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 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

Mother's maiden name (her surname before marriage)

If you are returning from the Armed Forces

Address before enlisting

Service or personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ 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

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

NEW PATIENT HEALTH QUESTIONNAIRE (PRIVATE & CONFIDENTIAL)

The information you complete on this form is to help us assess and provide the support you need so it is important to give complete information. This information will be recorded on your medical records with the usual confidentiality guidelines applied. Do be aware that you may be asked to consent for sharing of this information by future employers

Family name: …….. Title: Mr ☐ Ms ☐ Mx ☐ Dr ☐ Prof ☐ Other……

First names: …… …… Date of birth (DD/MM/YYYY)……..

UK Mobile Tel: …… Email address……..……

Emergency Contact (Next of Kin)…….Relationship to you……

Contact number……

Emergency contact person in the **UK (if different to above)** Name: ……..

Address: ……

Relationship to you: ……Telephone Number: ……

Appointments may be automatically sent to your phone by SMS. You may also get a reminder of your appointment the day before. SMS and email are a useful way for the Health Centre to contact you when we cannot reach you by phone call directly.

Do you consent to being contacted / reminded via SMS? Yes ☐ / No ☐

Do you consent to being emailed? Yes ☐ / No ☐

Information (answer as appropriate)

Are you a ……☐ UK student ☐ International student ☐ Staff member

Are you a…..☐ Undergraduate ☐ Postgraduate ☐ Postgraduate research

Student/Staff Card ID Number: …… Course/Subject ……

Campus …….. School/Department ……

Date course started (mm/yy) …….. Length of course (years) ……

Language Support

Is English your first language? Yes ☐ / No ☐

If English is not your first language which language is your first? ……

Will you need an interpreter to help you at medical appointments? Yes ☐ / No ☐

Other Support

Do you have a disability that has a substantial effect on your ability to carry out normal day-to-day tasks?

Yes ☐ / No ☐ *(If Yes please describe)* ……..……..

Do you use anything to help with your mobility, hearing or speaking? Yes ☐ / No ☐

If yes, please tick any of the list below which you use:

☐ A wheelchair ☐ A walking aid ☐ A hearing aid ☐ An advocate

☐ Hearing loop ☐ Text phone ☐ British Sign Language ☐ Other……

☐ Lip read ☐ Makaton ☐ Braille

Marital Status

☐ Single ☐ Married ☐ Civil partnership ☐ Separated ☐ Divorced ☐ Widowed

Gender Identity

Do you identify as:

☐ Female ☐ Male ☐ Other…… ☐ Do not wish to answer

Is your Gender Identity the same as the gender you were assigned at birth?: Yes ☐ No ☐

Sexual Orientation

Do you identify as:

☐ Heterosexual ☐ Bisexual ☐ Lesbian ☐ Gay ☐ Not sure ☐ Other …… ☐ Do not wish to answer

Beliefs or Religious practices

☐ Buddhist ☐ Christian ☐ Humanist ☐ Hindu ☐ Jehovah's Witness

☐ Jewish ☐ Muslim ☐ Sikh ☐ None ☐ I do not wish to answer.

☐ Agnostic ☐ Atheist Other (please state)……

Please state any treatments you cannot receive for religious reasons? ……

Ethnicity

To which of the groups listed below do you belong to?

Arab or Arab British

☐ Middle Eastern ☐ North African ☐ Any other Arab background (Please state)……

Asian or Asian British

☐ Bangladeshi ☐ East African Asian ☐ Indian ☐ Pakistani ☐ Sri Lankan
☐ Tamil ☐ Any other Asian background (Please state) ……

Black or black British

☐ Black Caribbean ☐ Black African ☐ Any other Black background (Please state) ……

Mixed

☐ Mixed Asian (please state) …… ☐ Mixed Black (please state) ……
☐ Mixed White (please state) …… ☐ Any other Mixed background (please state)……

White or White British

☐ White English ☐ White Irish ☐ White Scottish ☐ White Welsh ☐ White European
☐ Any other White background (please state) ……

Other or Other British Ethnic Group

☐ Chinese ☐ Filipino ☐ Japanese ☐ Iranian ☐ Kurdish ☐ Vietnamese
☐ Other (please state) …… ☐ I do not wish to answer this question.

Immunisations

If you don't know the date but are confident you have had any of the following please answer YES in the appropriate box and try to find out the date and let the Health Centre know later on this term.

Immunisations in bold will offered to you if you have not already had them.

Have you had the….. *Meningitis ACWY vaccine*	***Measles Mumps Rubella 1st dose***	***Measles Mumps Rubella 2nd dose***
Have you had? Yes ☐ No ☐ Year you had……..	Have you had? Yes ☐ No ☐ Year you had……..	Have you had? Yes ☐ No ☐ Year you had……..

Please list all countries you have lived in or visited for a period of longer than 6 months within the last 5 years

……

Have you ever been tested or treated for TB? Yes ☐ / No ☐

Family History

Does anyone in your close family have any medical conditions? Yes ☐ / No ☐ / Don't know ☐

e.g. heart disease/stroke/hypertension/asthma/diabetes/cancer/eczema/psoriasis/mental health/epilepsy/glaucoma?

Illness	Member of family	Age problem started

Past medical history and current medical problems

Please include anything that has required you to attend a hospital out-patient department. Please indicate *yes* or *no*.

Medical Condition		Which Condition?	Date of Diagnosis	Still a current condition?	Medication/Treatment
Acne or Eczema or Psoriasis	Yes ☐			Yes ☐ / No ☐	
ADHD	Yes ☐			Yes ☐ / No ☐	
Anxiety and/or Depression	Yes ☐			Yes ☐ / No ☐	
Bipolar Disorder or Schizophrenia	Yes ☐			Yes ☐ / No ☐	
Eating Disorder	Yes ☐			Yes ☐ / No ☐	
Personality Disorder	Yes ☐			Yes ☐ / No ☐	
Diabetes	Yes ☐			Yes ☐ / No ☐	
Asperger syndrome or Autistic Spectrum	Yes ☐			Yes ☐ / No ☐	
Epilepsy	Yes ☐			Yes ☐ / No ☐	
Asthma	Yes ☐			Yes ☐ / No ☐	
Inflammatory Bowel Disease or Coeliac Disease	Yes ☐			Yes ☐ / No ☐	
Dyslexia	Yes ☐			Yes ☐ / No ☐	
Thyroid disease	Yes ☐			Yes ☐ / No ☐	

Do you have any other medical conditions or broken bones (fractures) or operations that were not listed in the previous question?

……

……

……

Allergies

Are you allergic to anything? Yes ☐ / No ☐

If YES, what are you allergic to? ……..……...

And what reaction(s) do you get? ……

Lifestyle Information

Smoking history *(includes electronic cigarettes, vaping and shisha)*

☐Never Smoked ☐Current smoker ☐Ex-smoker

Form of smoking:

☐ Cigarettes ☐E-cigarettes ☐ Shisha smoker

If a current or ex-smoker, please tick amount nearest to how many cigarettes you smoke(d) per day

Less than 1 ☐ 1 -9 ☐ 10-19 ☐ 20-39 ☐ 40+ ☐

Are you aware that King's College NHS Health Centre has a Stop Smoking Service? Yes ☐ / No ☐

Alcohol

♦**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 alcoholic drinks do you have on a typical day when you are drinking?**

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+

♦**How often do you have 6 or more alcoholic drinks on one occasion?**

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

Activity/Exercise *(Please tick ONE box only).*

☐ I do less than 30 minutes per day of moderate to heavy intensity exercise on at least 5 days per week.

☐ I do at least 30 minutes per day of moderate intensity walking on at least 5 days per week.

☐ I do at least 30 minutes per day of moderate to heavy intensity exercise on at least 5 days per week

Measurements:

Height (meters) ……..…… Weight (kg) ……..…… Waist (cm) ……..……..

Drugs:

Have you used any of these drugs in the past?

☐ Cannabis ☐ Cocaine ☐ Crystal Meth ☐ GHB/GBL ☐ Heroin ☐ Ketamine

☐ Legal highs ☐ MDMA ☐ Mephedrone ☐ Other (please state) ……☐ None

Do you still currently use any of the drugs above? If yes please state which Yes ☐ / No ☐

……

Sexual Health

What method of contraception or barrier do you use? *(you may tick more than one box).*

☐ None ☐ Sterilised ☐ Partner sterilised ☐ Implant ☐ IUD

☐ IUS ☐ Injection ☐ Condoms ☐Female condom ☐ (Dental) dam

☐ Diaphragm ☐ Cap ☐ Vaginal ring ☐ Patch ☐ Withdrawal

☐ Combined pill ☐Progestogen-only pill ☐ I am not sexually active

Are you aware that the Health Centre has an implant-, IUS - and IUD- fitting service? Yes ☐ / No ☐

Screening:

Under 25s

If you are under 25 you may collect a free self-test chlamydia kit from the Health Centre waiting room.

(Further information on the Chlamydia Screening Programme is available on our website).

This box of questions is for people with a cervix/uterus:

Have you ever had a cervical smear (pap) test? Yes ☐ / No ☐

When	Where	Result	Recall date

(If your test was done outside of the UK please bring in or email a copy of the result or *complete a form at reception with the result details* to enable us to send you appropriate recall reminders).

This question is for people with testicles:

Are you aware of testicular self-examination for early detection of cancer? Yes ☐ / No ☐

(Please collect a leaflet from the Health Centre or view the A-Z Health Index on our website for more info*).*

Over 40s

Are you aware that you are entitled to a free cardiovascular disease risk assessment at the Health Centre?

(Please book an appointment for a free NHS Health Check). Yes ☐ / No ☐

This question is for people with breasts and are over the age of 47:

Have you had a mammogram in the past 3 years? Yes ☐ / No ☐ Result……Date had……

Food:

How many of the following do you eat every day? *(please fill in the number)*

Portion of fruit …….. Serving of vegetables/salad …… ... Juice/smoothie …… Vegetable soup.....……..

If any of the following apply to you then please see one of the nurses so that they can take the details and advise on any needed/available support:
If you have returned from the armed forces, If you are a carer, If you have difficulty taking medications
If you have a living will

SYSTMONLINE:

With SystmOnline you can book GP appointments, request repeat prescriptions, view results and view a summary of your patient record all through your computer, tablet or phone. If you would like to sign up for this system please tick yes below and we will send you your log in information.

Do you wish to sign up to use SystmOnline? Yes ☐

Sharing Your Medical Record

Each NHS patient registered with a General Practitioner (GP) has a medical record. Until now, that record has been held by the patient's GP and was not able to be viewed by other health professionals. Practices are moving on to the same IT system which means it will be easier for IT systems to talk to each other so now it is possible for NHS providers to view the medical records and record clinical information in the same shared set of notes if the patient gives consent. The provider cannot access a patient's record without their express consent. However if a GP practice does not put the records in this shared, secure space it means that the patient cannot allow another healthcare professional to see there notes even if they want them to.

- ✓ Reduces unnecessary duplication in diagnostic tests e.g. having blood samples taken
- ✓ Reduces the number of times patients need to tell their history to new health professionals
- ✓ Helps patients get safer care, for example avoiding patients being given inappropriate medications or medications they are allergic to or enabling a consultant to access key information
- ✓ Enables specialist consultants and other services that see a patient to add important information into the records for the patient's GP to see

Do you wish to share your GP record? Yes ☐ / No ☐

Summary Care Record

Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. It provides authorised care professionals with faster, secure access to essential information about you when you need care. They are accessible to authorised health care staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record.

Do you wish to have a Summary Care Record? Yes ☐ / No ☐

NAME (Block Capitals)……DOB……......

Signature ……..

Today's Date: ……

Thank you for taking the time to complete this form
Please return this form with your completed GMS1 form to the Health Centre.
You are invited to make an appointment with one of the health care assistant/nurses for a new patient health check. They can assess and advise you on any health needs and give you information about the services offered to you.