**ELLERGREEN MEDICAL CENTRE**

**NEW PATIENT REGISTRATION**

**PLEASE BRING VACCINATION RECORD BOOK OR LIST OF IMMUNISATIONS GIVEN FOR 24 YEARS AND UNDER**

Welcome to Ellergreen Medical Centre. In order to register with this surgery we require you to complete form GMS1 and a New Patient Questionnaire. Please complete these and hand them to the receptionist. We aim to process your application within 3 working days but this may take longer in some instances.

Please help us by providing evidence of medication that you are taking i.e. the right-hand side of your prescription, your medication boxes or a print out from your previous GP. These must have your name for identification purposes.

We will ask you if you would like to provide any identification or proof of address in order to assist in validation of our records, and minimise the risk of you being registered incorrectly. If you are able to submit evidence, this will be scanned onto your medical record. However if you are unable to provide any proof of identity you can still register.

If you would like more information about registering with a GP please log on to [www.nhs.uk](http://www.nhs.uk)

**When you hand in your questionnaire into us, we will ask you if you would like to register for Online Access. This will enable you to book and cancel appointments and order repeat prescriptions from any location with internet access. We will ask you what level of online access you require.**

The website below explains how you can make informed choices over your data.

www.nhs.uk/your-nhs-data-matters

**ELLERGREEN MEDICAL CENTRE**

**New Patient Health Questionnaire for Adults**

**Your contact details**

Title Mr O Mrs O Miss O Ms O

Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_ First Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

House Name/House Number \_\_\_\_\_\_\_ Home Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information about you**

What is your height? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your weight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your first language?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need an interpreter? Yes O / No O

**Ethnic Group**

White British O Irish O Other O please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Black Caribbean O African O Other O Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asian Indian O Pakistani O Chinese O

Other O Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mixed White + Black Caribbean O

White + Black African O

White + Asian O

Other O please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever served in the British armed forces? Yes O No O

If yes in what year did you leave the British armed forces?

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| **Please tell us any communication needs you may have.** |

**Religion**

Church of England O Christianity O Buddhism O Jehovah’s Witness O

Roman Catholic O Sikhism O Hinduism O Islam O

Other religion please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous GP**

Name and Address of Previous GP

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**Medical Information**

Please list any serious illnesses/operations/accidents/disabilities (for women any pregnancy related problems, and the year they took place.

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Have you suffered from? (tick as appropriate)

Epilepsy Yes O /No O Blindness/Glaucoma Yes O /No O

High Blood Pressure Yes O /No O Diabetes Yes O /No O

Heart Attack/Stroke Yes O /No O Cancer Yes O /No O

Asthma Yes O /No O Eczema/Hay Fever Yes O /No O

COPD Yes O /No O

If yes please state the year when you were first diagnosed

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Please list the strength, dose and daily amount of any medicines being taken:

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**If you have a nominated pharmacy for electronic prescriptions, this is automatically carried across. If you wish to change your nominated chemist, you must let your new chosen pharmacy know.**

Are you disabled? (if yes, please give details) Yes O /No O

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Are you allergic to any medicines and if so which? Yes O /No O

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Have you ever refused treatment/screening of any kind and if so, what and when? Yes O /No O

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Have you ever suffered from? (tick as appropriate)

Anxiety Yes O /No O Depression Yes O /No O

OCD Yes O /No O Bipolar Disorder Yes O /No O

Substance Misuse Yes O /No O

If yes to any of these, please state the year when you were first diagnosed?

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Do you have any other mental health issues? (if yes please give details)

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Are you receiving or have you received any mental health treatment or therapy?

(if yes please give details of your care and when you received it)

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**Carers**

Do you have a carer? (if yes please give details including their name and Date of Birth) Yes O /No O

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Are you a carer? (if yes please give details including their name and Date of Birth) Yes O /No O

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**Women**

Have you ever had a cervical smear? (if yes please state when, where and the result) Yes O /No O

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| --- |
|  |

Have you ever had breast screening ( if yes please state when and the result) Yes O /No O

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**Smoking**

Do you smoke? Yes O/No O

If so how many cigarettes do you smoke a day?

If ‘No’ have you ever smoked? Yes O/No O

If you are an ex-smoker, how many cigarettes or ounces of tobacco did you smoke per day?

For advice on giving up smoking, the number for SmokeFree Liverpool is 0800 061 4212 or 0151 374 2535.

**Alcohol**

**Please try and answer the questions below or we can help you fill this in when you come to see us.**

Are you teetotal? YES / NO

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirits

How many units do you estimate that you drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often did you have a drink containing alcohol in the past year? (please tick)

Never O Monthly or less O 2-4 times a month O

2-3 times per week O 4+ times per week O

1. How many standard units did you have on a typical day when you were drinking in the past year?

1 or 2 O 3 to 4 O 5 to 6 O 7 to 9 O 10 or more O

1. How often did you have 6 or more standard units on one occasion in the past year?

Never O Less than monthly O Monthly O

Weekly O Daily or almost daily O

Free help and support is available to help reduce alcohol consumption. The immediate effects of cutting down will mean you are likely to feel less tired, your skin will look better and you’ll feel in better shape. If you find cutting down difficult we can put you in touch with people who can help.

**Physical Activity**

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| --- | --- |
| Think about what **activities** you do in a typical week that make you more out-of-breath than normal . This might be brisk walking; gardening; cycling; sport such as football or going to the gym. | |
| How many days per week do you usually do any of these activities? |  |
| How much time each day do you spend doing these activities? |  |

**Family History**

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure. Diabetes, or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

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**Next of Kin**

Please give name, address and telephone number of next of kin.

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| --- |
| Name:  Contact Number:  Relationship:  Address: |

**For patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes)**

Have you had a flu vaccination? Yes O /No O. If yes please enter the date of your last flu vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a pneumococcal vaccination? Yes O /No O. If yes please enter the date of your last pneumococcal vaccine \_\_\_\_\_\_\_\_\_\_­­­­­­­­­

**Contacting you**

I am happy for the practice to contact me from time to time via **text** with practice news, health advice and/or appointment reminders. Yes O / No O

I am happy for the practice to contact me from time to time via **email** with practice news, health advice and/or appointment reminders. Yes O / No O

**Online Access**

Please indicate with a tick which level of online access you require:-

Standard Access (booking appointments, requesting repeat medication, allergies) O

Enhanced Access (problems, results) O

I do not wish to have online access O

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **For Office use only :** | **Proof of Identity and Address Provided**  O Birth Certificate O Driving Licence O Passport O Utility Bill O Allowance Book  O Solicitors Letter O Offer of Tenancy O Other  Specify I.D.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specify Proof of address……………………………  **Verified by (please initial)……………………………………………………………………………………** |

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