Leylands Medical Centre

Dr Brooke | Dr Larsen | Dr Okeahialam | Dr Padfield | Dr Bhamani

Dear Patient

Welcome to Leylands Medical Centre. In addition to the GMS1 form we ask that you complete our own new patient registration form. This will enable us to provide the best care for you. All information will be held in the strictest confidence.

Quick tips:

- For all up to date information about the practice, visit: www.leylandsmedicalcentre.nhs.uk
- Remember to register for our text message reminder service if you use a mobile phone
- Remember to register for our online services to let you order repeat medication, make appointments, send and receive secure messages plus more.

Title		Male☐ Female☐	
First Name(s)			
Surname			
DOB:	DD	MM	YYYY
Address:			
Town:			
Postcode:			
Home phone:		Preferred?☐	
Mobile:		Preferred?☐	SMS consent☐
Work		Preferred?☐	
Email:			
Ethnicity:	**White** ☐English☐Welsh☐ Scottish☐ Northern Irish ☐British ☐Irish ☐Gypsy or Irish Traveller ☐Any other White background, please describe: **Mixed / Multiple ethnic groups** ☐White and Black Caribbean ☐White and Black African ☐White and Asian ☐Any other Mixed / Multiple ethnic background, please describe: **Asian / Asian British** ☐Indian ☐Pakistani ☐Bangladeshi ☐Chinese ☐Any other Asian background, please describe:	**Black / African / Caribbean / Black British** ☐African ☐Caribbean ☐Any other Black / African / Caribbean background, please describe **Other ethnic group** ☐Arab ☐Any other ethnic group, please describe:	

Are you registered disabled?	yes☐ no☐	Details:
Are you a carer?	yes☐ no☐	Details:
Do you have a carer?	yes☐ no☐	Details:

☐ I have never smoked		
☐ I am a current smoker	How many cigarettes per day?	
☐ I am an ex-smoker	When did you give up?	

☐ I do not drink alcohol		
☐ I drink alcohol	How many units per week?	
(One unit = ½ pint, one small glass of wine or one pub measure of spirit)		

☐ I undertake no regular exercise ☐ I exercise once or twice a week ☐ I exercise more than twice a week

Do you suffer from or have you ever suffered from any of the following?

Heart disease:	☐ yes ☐no, if yes, give details:	Kidney disease:	☐ yes ☐no, if yes, give details:
Stroke:	☐ yes ☐no, if yes, give details:	Thyroid disease:	☐ yes ☐no, if yes, give details:
High blood pressure:	☐ yes ☐no, if yes, give details:	Thalassaemia:	☐ yes ☐no, if yes, give details:
Diabetes:	☐ yes ☐no, if yes, give details:	Arthritis:	☐ yes ☐no , if yes, give details:
Asthma:	☐ yes ☐no, if yes, give details:	Cancer:	☐ yes ☐no , if yes, give details:
Epilepsy:	☐ yes ☐no, if yes, give details:	Muscle/joint problem:	☐ yes ☐no , if yes, give details:
Mental Illness:	☐ yes ☐no, if yes, give details:	Other (including operations)	☐ yes ☐no , if yes, give details:

Has anyone in your family ever suffered from the following? (Parents, brothers and sisters **only**)

		Brief details	Age at first occurrence	
			Under 60	Over 60
Heart disease:	☐ yes ☐no			
Stroke	☐ yes ☐no			
High blood pressure	☐ yes ☐no			
Diabetes	☐ yes ☐no			
Cancer	☐ yes ☐no			
Other	☐ yes ☐no			

MEDICATION:

☐I do not take regular medication	
☐I take regular medication	Please provide details or repeat medication slip from last practice.
Do you have any allergies to any medication? If so, please state and what reaction did you have?	

Do you wish to give permission for any other person to have access to any results/correspondence or speak to the practice on your behalf? If yes, please give details below:

Signed (patient):	
Date:	

Thank you for completing for this form. Please bring it with you to your new patient health check with the nurse