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](http://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 | Click here to enter text. | Male[ ]  Female[ ]   |
| First Name(s) | Click here to enter text. |
| Surname | Click here to enter text. |
| DOB: | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Address: | Click here to enter text. |
| Town: | Click here to enter text. |
| Postcode: | Click here to enter text. |
| Home phone: | Click here to enter text. | Preferred?[ ]  |
| Mobile: | Click here to enter text. | Preferred?[ ]  | SMS consent[ ]  |
| Work | Click here to enter text. | Preferred?[ ]  |
| Email: | Click here to enter text. |
| 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:Click here to enter text. |
| Are you a carer? | yes[ ]  no[ ]  | Details:Click here to enter text. |
| Do you have a carer? | yes[ ]  no[ ]  | Details:Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| [ ]  I have never smoked |  |  |
| [ ]  I am a current smoker | How many cigarettes per day? | Click here to enter text. |
| [ ]  I am an ex-smoker | When did you give up? | Click here to enter text. |

|  |  |  |
| --- | --- | --- |
| [ ]  I do not drink alcohol |  |  |
| [ ]  I drink alcohol | How many units per week? | Click here to enter text. |
| (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: Click here to enter text. | Kidney disease: | [ ]  yes [ ] no, if yes, give details:Click here to enter text. |
| Stroke: | [ ]  yes [ ] no, if yes, give details:Click here to enter text.  | Thyroid disease: | [ ]  yes [ ] no, if yes, give details:Click here to enter text. |
| High blood pressure: | [ ]  yes [ ] no, if yes, give details:Click here to enter text. | Thalassaemia: | [ ]  yes [ ] no, if yes, give details:Click here to enter text. |
| Diabetes: | [ ]  yes [ ] no, if yes, give details:Click here to enter text.  | Arthritis: | [ ]  yes [ ] no , if yes, give details:Click here to enter text. |
| Asthma: | [ ]  yes [ ] no, if yes, give details:Click here to enter text.  | Cancer: | [ ]  yes [ ] no , if yes, give details:Click here to enter text. |
| Epilepsy: | [ ]  yes [ ] no, if yes, give details:Click here to enter text.  | Muscle/joint problem: | [ ]  yes [ ] no , if yes, give details:Click here to enter text. |
| Mental Illness: | [ ]  yes [ ] no, if yes, give details:Click here to enter text. | Other (including operations) | [ ]  yes [ ] no , if yes, give details:Click here to enter text. |

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  | Click here to enter text. |[ ] [ ]
| Stroke | [ ]  yes [ ] no  | Click here to enter text. |[ ] [ ]
| High blood pressure | [ ]  yes [ ] no  | Click here to enter text. |[ ] [ ]
| Diabetes | [ ]  yes [ ] no  | Click here to enter text. |[ ] [ ]
| Cancer | [ ]  yes [ ] no  | Click here to enter text. |[ ] [ ]
| Other | [ ]  yes [ ] no  | Click here to enter text. |[ ] [ ]

MEDICATION:

|  |  |
| --- | --- |
| [ ] I do not take regular medication |  |
| [ ] I take regular medication  | Please provide details or repeat medication slip from last practice. Click here to enter text. |
| Do you have any allergies to any medication? If so, please state and what reaction did you have? | Click here to enter text. |

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:

|  |
| --- |
| Click here to enter text. |

|  |  |
| --- | --- |
| Signed (patient): |  |
| Date: | Click here to enter text. |

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

PRACTICE USE ONLY: IDENTITY VERIFIED SYSTMONLINE REGISTRATION COMPLETED

 LOGIN DETAILS GIVEN TO PATIENT

 FORWARD FOR SCANNING STAFF INITIALS