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**  EnglishWelsh 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