

**Family doctor services registration**  
**PLEASE COMPLETE USING BLOCK CAPITALS**

GMS1

Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Surname
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Previous Surname/s:	Date of Birth:     /     /
First Names:	Town & country Of birth:

Title: Mr  Mrs  Miss  Ms  Other:

Current Address:

  
  
  
  

Post Code:  
Telephone No:  
Mobile No:

Previous Address:

  
  
  
  

Post Code:

Name of previous **doctor** and address of **surgery**:

**If you are from abroad.** Your first UK address at which registered with a GP:

  
  
  
  

**Date you first came To live in UK:**             /             /

**If you are returning from the Armed Forces**  
Home address before you enlisted:

  
  
  
  

Postcode:

Service or Personnel number:

  
  

Enlistment Date:             /             /

**If you are registering a child under 5.** We will register them for Child Health Surveillance (regular health checks by a doctor & health visitor) unless you place a cross in this box

<b>NEXT OF KIN /EMERGENCY CONTACT DETAILS</b> (this section is optional)	N.O.K. Name:
Relationship:	Contact Tel No:

**Signature of patient or on behalf of patient**

**Date:**

**WHAT IS YOUR ETHNIC GROUP** (this section is optional)

Choose **ONE** section from **A to E**, then ✓ **the appropriate box to indicate your cultural background**

<b>A. White</b>	<input type="checkbox"/> British <input type="checkbox"/> Irish
	<input type="checkbox"/> Any other White background
<b>B. Mixed</b>	<input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Black African
	<input type="checkbox"/> White & Asian <input type="checkbox"/> Any other Mixed background
<b>C. Asian or Asian British</b>	<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi
	<input type="checkbox"/> Any other Asian background
<b>D. Black or Black British</b>	<input type="checkbox"/> Caribbean <input type="checkbox"/> African
	<input type="checkbox"/> Any other Black background
<b>E. Chinese or other ethnic group</b>	<input type="checkbox"/> Chinese
<b>F. Ethnic group not stated</b>	<input type="checkbox"/>

What is your first language? .....

Do you speak English      Yes       No

<b>Carer Details (this section is optional)</b>	Are you a Carer? (i.e. do you look after someone who is unwell?) <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(Ub1ju)</b>
	Do you have someone who acts as a Carer for you? <input type="checkbox"/> Yes <input type="checkbox"/> No      - If your answer is yes please give details: Carer's Name: <b>(918F)</b> Carer's Telephone Number:

**ORGAN DONOR REGISTRATION** (this section is optional)

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. *Please tick as appropriate:*

Kidneys     Heart     Liver     Corneas     Lungs     Pancreas     Any part of my body

**Signature confirming consent to organ donation**

**Date:**    /    /

**NHS BLOOD DONOR REGISTRATION** (this section is optional)

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood

Tick here if you have given blood in the last 3 years   

**Signature confirming consent to inclusion on the NHS Blood Donor Register**

**Date:**    /    /

<b>GP Office use</b> Registered GP:  HA Code:
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<b>Hyde Park Surgery</b> <b>Woodsley Road</b> <b>Leeds LS6 1SG</b>
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## HEALTH QUESTIONNAIRE

This will be important in helping your doctor to provide you with the best medical care.  
Please answer all the questions.

Your Name

Your Date of Birth

### GENERAL HEALTH

What is your height?

What is your weight?

**ALCOHOL CONSUMPTION** (Please tick the box to indicate your answer to each question)

How often do you have a drink that contains alcohol?	NEVER	MONTHLY OR LESS	2-4 TIMES PER MONTH	2-3 TIMES PER WEEK	4+ TIMES PER WEEK
How many standard 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 standard drinks on one occasion?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY

**SMOKING STATUS** (Please tick the box to indicate your answer to each question)

**Are you:**

- A current smoker?
- An ex-smoker?
- Someone who's never smoked?

Some of our Nurses are trained smoking cessation advisers. If you smoke and would like help to stop, ask the receptionist for an appointment.

**CERVICAL SMEARS** (for females aged 25-64)

**Have you ever had a cervical smear?** YES  NO  DON'T KNOW

If yes, in what month & year was the last one done? .....

Where were you living .....

Who was the smear done by? GP  Another clinic

**HYSTERECTOMY** If you have had a hysterectomy please tell us the month and year

Month ..... Year .....

We recommend that all women aged 25-64 have a cervical smear every 3 years. Our Practice Nurses are trained to do this for you. Please make an appointment if you are due to have a smear.



## SUMMARY CARE RECORD

The summary care record is a national database for the NHS and holds details of your name, date of birth, allergies and any medication you are taking.

Your record will be automatically uploaded onto this database.

- **YES I would like a summary care record** - you do not need to do anything and a summary care record will be created for you
- **NO I do not want a summary care record** - ask at reception for the "opt out form" - complete the form and hand it to a receptionist. Your record will be removed from the database

For more information ask at reception