

Patient's details

Please complete in BLOCK CAPITALS and tick as appropriate

Mr Mrs Miss Ms
 Date of birth: _____
 Surname: _____
 First names: _____
 Previous surnames: _____
 Town and country of birth: _____
 Male Female
 Home address: _____
 Telephone number: _____
 Postcode: _____

Please help us trace your previous medical records by providing the following information

Your previous address in UK: _____
 Name of previous doctor while at that address: _____
 Address of previous doctor: _____

If you are from abroad

Your first UK address where registered with a GP: _____

If previously resident in UK, date of leaving: _____
 Date you first came to live in UK: _____

If you are returning from the Armed Forces

Address before enlisting: _____

Service or Personnel number: _____
 Enlistment date: _____

If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

I live more than 1 mile in a straight line from the nearest chemist
 I would have serious difficulty in getting them from a chemist
 Signature of Patient Signature on behalf of patient

Date

*Not all doctors are authorised to dispense medicines

NHS Organ Donor registration

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 _____

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHS Blood Donor registration

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 _____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
 My preferred address for donation is: (only if different from above, e.g. your place of work) _____
 Postcode: _____

To be completed by the doctor

Doctors Name _____

HA Code _____

- I have accepted this patient for general medical services
 For the provision of contraceptive services
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above _____

HA Code _____

I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**

I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above _____
 HA Code _____

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.
 Distance in miles between my patient's home address and my main surgery is _____

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature _____

Name _____

Date _____

Practice Stamp _____

SID VALLEY PRACTICE HEALTH PROMOTION QUESTIONNAIRE

Please complete this Questionnaire to help us record useful data on your medical records. All this information is kept confidentially. If you have anyone in your household who has not attended the Health Centre for some time, perhaps you could take extra copies for them to complete.

FULL NAME

DATE OF BIRTH

LAST PROFESSIONAL OCCUPATION

(Retired not sufficient)

ALCOHOL CONSUMPTION

I currently drinkUnits per week

I am a Lifelong Teetotaler

I am an Ex-Drinker

(One unit of alcohol = ½ pint beer or 1 small glass of wine or 1 spirit measure)

SMOKING - Do you smoke?

YES/NO

Have you ever smoked?

YES/NO

What and how many do you, or did you smoke?

.....Cigarettes per day (average)Cigars per day (average)Tobacco ounces per day (average)
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Number of years smoked?

Ex-smokers - Have you smoked in the last 3 years?

YES/NO

If ex-smoker – Year you gave up

If you smoke we can help you give up. We can offer Nicotine Replacement Therapy medication on prescription and/or help and advice from the Smoking Cessation Service. Please ring Devon Stop Smoking on 0845 1111 142.

ALLERGIES – Do you have any allergies – if so please state

EXERCISE – Indicate which correctly describes your exercise regime

Exercise physically impossible	Enjoys light exercise	Enjoys moderate exercise	Enjoys heavy exercise
Aerobic exercise 1 time/week	Aerobic exercise 2 time/week	Aerobic exercise 3 times/week	Aerobic exercise more than 3 times/week

DIET – Indicate which of the following most closely describes your diet?

Diet Good	Diet Poor	Diet Average	High Fibre Diet
Vegan/Strict Vegetarian	Diet Low in Fat	Diabetic Diet	Weight Reducing Diet

SOCIAL HISTORY – Do you have any dependants at home?

Are you a Carer? (e.g. elderly relatives or children)

YES / NO

FAMILY HISTORY – Indicate if first degree relatives - father, mother, brother or sister has a history of

Diabetes	High Blood Pressure	Heart Attack/Angina Under 60	Heart Attack/Angina Over 60
Asthma	Bowel Cancer	Breast Cancer	Prostate Cancer
Ovarian Cancer	Stroke	Glaucoma	Epilepsy

CHEMIST – Please indicate which Chemist you would like your prescriptions to be sent to

BOOTS	WOOLBROOK	LLOYDS SIDMOUTH	LLOYDS SIDFORD
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ETHNIC ORIGIN FORM

NHS Organisations are required to collect details about ethnicity. This information is collected to fulfil that obligation and is used for monitoring purposes only.

I would describe my ethnic origin as follows:

Asian or Asian British

- Bangladeshi
- Indian
- Pakistani
- Any other Asian background *

*Please describe _____

Black or Black British

- African
- Caribbean
- Any other Black background *

*Please describe _____

Mixed

- White & Asian
- White & Black African
- White & Black Caribbean
- Any other mixed background *

*Please describe _____

White

- British
- Irish
- Any other white background *

*Please describe _____

Other Ethnic Group

- Chinese
- Any other ethnic group

**I do not wish to disclose my
Ethnic origin**

SID VALLEY PRACTICE

PATIENT REGISTRATION DECLARATION

(To be completed in addition to Family Doctor Services Registration form GMS1)

In order to register with a Family Doctor please answer the following questions IF you have been living outside of the UK in the last 12 months.

Where have you lived for the last 12 months?

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If previous resident of UK - date of leaving

Date you returned/entered UK

What is the basis for your stay in the UK?

Are you planning to remain in the UK permanently?

If No, state length of time you plan to remain in UK

Can you show that you have the right to live here? (i.e. Passport, Visa or a letter from the Home Office)

.....
Print Name

.....
Signature

.....
Date of Birth

Please note - If a patient does not intend to live in the UK on a settled basis a GP practice does not have to accept them as an NHS patient, however we may offer to treat the person as a private patient for which we may charge.

If a patient comes from a country with which the UK holds a healthcare agreement, they will not have a pay for treatment for a condition that started after their arrival in the UK and that is needed immediately.

Patients may be asked to give proof of their claim that they are on a short term visit, such as passport or identify card, or travel documents. These patients will still have to pay the statutory NHS charges, such as prescription charges, unless they qualify for exemption from these.