

Application to Register with a General Medical Practitioner

Please complete in **block capitals** and tick relevant boxes

Patient details

Surname Address
 Forename
 Previous Surname
 Date of birth
 Male Female
 I wish the child named above to be registered at the practice for Child Health Surveillance
 Post code
 Relationship to patient I will be in the area for more than three months

Patient's / Patient's representative signature Date

Voluntary consent to organ donation

If you wish to register on the NHS Organ Donor Register as someone whose organs can be used for transplantation purposes after your death, please tick relevant box(es) below:

Any Organ Kidneys Liver Lungs Heart Corneas Pancreas
 Patient's signature Date

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

NHS No. (not National Insurance No.) Community Health Index (CHI) No.
 Previous address in U.K. Name and address of previous doctor in U.K.
 Town
 County Post code
 If returning from abroad Date of departure from U.K.
 Date of return to U.K. If returning from HM Forces Date enlisted Service / Personnel No.

If none of the above information is known then please complete the following:

Town of birth Reg. district of birth (see birth certificate)
 County of birth Mother's maiden name

Doctor's agreement

Enter 'D' if supplying drugs Mileage claim road water footpath
 CHS acceptance yes no Enter date if registration examination completed
 I accept this patient on my list and I claim payment in accordance with the Regulations. CHS Ref No. of GP providing service if different from below
 Doctor's signature Date Doctor's name GP Ref. No.

BLACKFRIARS MEDICAL PRACTICE

NEW PATIENT MEDICAL QUESTIONNAIRE

PERSONAL DETAILS

Title & Full Name: _____

Date of Birth: _____

Full Address: _____

Post Code: _____

Home Telephone Number: _____

Alternative Telephone Number: _____

CURRENT MEDICAL DETAILS

Do you smoke? YES / NO. If yes, how many cigarettes per day _____

Are you an ex-smoker? YES / NO

Do you drink alcohol? YES / NO. If yes, how many units per week _____

What is your weight? _____ What is your height? _____

Have you ever had a smear (**female patients only**) YES / NO

If yes, when was this taken? _____

What was the result? NEGATIVE / ABNORMAL

Do you have any allergies? YES / NO. If yes, please provide details _____

PAST MEDICAL HISTORY

Please detail all important, previous, illnesses, hospital admissions and operations with dates:

Are you on any regular medication? YES / NO. If yes, please provide details:

Have any of your relatives had any of the following conditions? If so, please detail who:

Asthma _____

Heart Disease _____

Epilepsy _____

Diabetes _____

Stroke _____

High Blood Pressure _____

Have you ever had any immunisations / vaccinations? YES / NO. If yes, please provide details with dates:

OTHER INFORMATION