**The Allan Practice**
**Calcot Medical Centre, Hampden Road, Chalfont St. Peter, Gerrards Cross, Bucks, SL9 9SA**
**01753 887 311 | contact.theallanpractice@nhs.net**

**Registering as a patient at The Allan Practice**

We are very pleased that you would like to register as a patient at The Allan Practice. Please complete the attached registration form and Patient Health Questionnaire. If you are registering children, a separate form and questionnaire must be completed for each child. Photographic proof of identity and proof of address (utility bill, council tax bill or bank statement. Mobile phone bills are unacceptable) will be required for each prospective patient. We will be unable to register you without seeing the original documentation required, copies are not accepted.

| **To register at The Allan Practice you will need:** | |
|---|---|
| **For UK Nationals** | **Checklist \| Office Use Only** |
| 1) Completed GMS1 Form<br>2) Valid Photographic ID<br>3) Proof of Address | |
| **For patients from the EU** | **Checklist \| Office Use Only** |
| 1) Completed GMS1 Form *This must include the date you moved to the UK<br>2) Valid Passport or National Identity Card<br>3) Proof of Address | |
| **For Patients from Non-EU Countries** | **Checklist \| Office Use Only** |
| 1) Completed GMS1 Form *This must include the date you moved to the UK<br>2) Valid Passport<br>3) Valid Visa*<br>4) Proof of Address<br>*Your Visa details will be noted and you will have to present valid documents after expiry. | |
| NB: The possession of an NHS number does not necessarily entitle you to all NHS Services. | **Office Use Only Processed By** |
| **I am aware that processing my application may take up to 7 working days and that I am entitled to urgent, necessary care in the meantime.**<br>Patient Name: Date:<br>Patient Signature: | |

The Allan Practice

**Adult Health Questionnaire (Confidential)**

**Please print your answers clearly.**

| | | | |
|---|---|---|---|
| **Surname** | | | |
| **Forenames** | | | |
| **Address** | | | |
| | | | |
| | | | |
| | | | |
| **Postcode** | | | |
| **Title** | Mr / Mrs / Ms / Miss / Master / Dr / Rev / Other: | | |
| **Date of Birth** | | **Gender** | Male / Female |
| **Telephone Numbers** | | | |
| **Home** | **Work** | **Mobile** | |
| | | | |
| **E-mail** | | | |
| **I agree to receive communications via text messages or via email** | Yes / No | | |
| | | | |
| **Name of Next of Kin** | | | |
| **Relationship to you** | | | |
| **Telephone Numbers** | | | |
| **Home** | **Work** | **Mobile** | |
| | | | |
| **Emergency Contact** | | | |
| **Relationship to you** | | | |
| **Telephone Numbers** | | | |
| **Home** | **Work** | **Mobile** | |
| | | | |
| **Marital status** | Single / Married / Separated / Widowed / Divorced / Cohabiting | | |
| **Occupation** | | | |
| | | | |
| **What is your ethnicity?** | | | |
| **British** | **Irish** | **African** | **Asian** | **Bangladeshi** |
| **Caribbean** | **Chinese** | **Indian/British Indian** | **Pakistani/British Pakistani** | |
| **Other White (please state)** | | **Other Asian Background (please state)** | |
| **Other Black Background (please state)** | | **Other Mixed Background (please state)** | |
| **Other (please state)** | | **Not Stated** | |
| **What language do you speak?** | | | |
| **Do you use an interpreter?** | Yes / No | | |

**Medical History**

**Have you ever had, or received treatment for, any of the following conditions?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Thrombosis (blood clot)** | Y | N | **Glaucoma** | Y | N | **Asthma** | Y | N |
| **Tuberculosis** | Y | N | **High blood pressure** | Y | N | **Stomach ulcer** | Y | N |
| **Cancer** | Y | N | **Heart attack / disease** | Y | N | **Epilepsy / Convulsions** | Y | N |
| **Diabetes** | Y | N | **Angina** | Y | N | **Jaundice** | Y | N |
| **Rheumatic fever** | Y | N | **Stroke** | Y | N | **Depression** | Y | N |

| | | |
|---|---|---|
| **Do you have any current illnesses or have you had any other serious illness, injury or operation?** | Y | N |

**If yes, please give details, including approximate dates:**

**Medication**

| | | |
|---|---|---|
| **Do you take any medication, including the contraceptive pill? (If yes please state below)** | Y | N |

| **Medication Name** | **Strength & Dosage** | **Frequency** | **When was this started?** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | |
|---|---|---|
| **Do you have an allergy to any medicines?** | Y | N |
| **Please specify** | | |
| **Do you have any other allergies, e.g. peanuts, latex, bee stings?** | Y | N |
| **Please specify** | | |
| **Do you take any other medicines or dietary supplements?** | Y | N |
| **Please specify** | | |

**If you would like your prescriptions sent electronically to a pharmacy, please provide their name and postcode:**

**How much physical exercise do you do each week?**

| | |
|---|---|
| **None** | |
| **Up to one hour** | |
| **Up to three hours** | |
| **Three or more hours** | |

**Diet**

| | |
|---|---|
| **Are you on a special diet?** | Yes / No |
| **Please specify** | |
| **Would you describe your diet as healthy?** (i.e. at least 5 portions of fruit & vegetables per day and no more than 2 portions of red meat per week) | Yes / No |

**Women Only**

| | | | |
|---|---|---|---|
| **Are you using any form of contraception?** | Yes / No | **Details** | |
| **Have you ever had a cervical screening?** | Yes / No | **Date of last** | |
| **Have you ever had a mammogram (breast x-ray)?** | Yes / No | **Date of last** | |
| **Have you had rubella (German measles)?** | Yes / No | **Rubella vaccination?** | Yes / No |

**Family History**

**Is there a family history of any of the following conditions? If yes, please state which family member has the condition.**

| Condition | | | Family Member | Condition | | | Family Member |
|---|---|---|---|---|---|---|---|
| **Heart Attack** | Y | N | | **Bowel Cancer** | Y | N | |
| **Stroke** | Y | N | | **Prostate Cancer** | Y | N | |
| **High Blood Pressure** | Y | N | | **Diabetes** | Y | N | |
| **Heart Disease Under 60** | Y | N | | **Asthma** | Y | N | |
| **Heart Disease Over 60** | Y | N | | **Osteoporosis** | Y | N | |
| **Breast Cancer** | Y | N | | **Other** | Y | N | |

**Carers**

| | | |
|---|---|---|
| **Are you a carer?**<br>A carer provides unpaid support and care on a regular and substantial basis to a family member, friend or neighbour who would not be able to live independently without them due to frailty, illness or disability. | Y | N |
| **Do you have a carer?**<br>**If yes, please provide their details:** | Y | N |

**Military Personnel and Veterans**

| | | |
|---|---|---|
| **Have you ever served in the Armed Forces?**<br>**If yes, please state the length of your service & date of discharge if applicable:** | Y | N |
| **Are any of your direct relations a member of the Armed Forces?**<br>**Please specify:** | Y | N |

**Specific Needs**

| | | |
|---|---|---|
| **Do you have a sensory impairment?**<br>**Please specify:** | Y | N |
| **Do you have any physical disabilities?**<br>**Please specify:** | Y | N |
| **Do you have an Assistance Dog?** | Y | N |
| **Do you have any learning or psychological disabilities?**<br>**Please specify:** | Y | N |
| **Do you have a Lasting Power of Attorney?**<br>**If yes, please provide their details** | Y | N |

**Consent to Access Medical Records**

This practice holds medical records relating to the treatment and services patients receive. We are asking permission for your records to be looked at by external auditors assessing quality of care. These checks are supported as they help to ensure quality & efficiency of treatment in the NHS. The auditors who carry out these checks are bound by strict rules of confidentiality and your records will only be used for the purpose described.

| | |
|---|---|
| **I DO NOT consent to auditors looking at my medical records (please tick)** | |

**Summary Care Records**

Your Summary Care Record will contain information about your medications and allergies. It will be used for emergency care to ensure those caring for you have the information to treat you safely.

| | | |
|---|---|---|
| **I DO NOT want a Summary Care Record**<br>**Signed:** **Date:** | | |

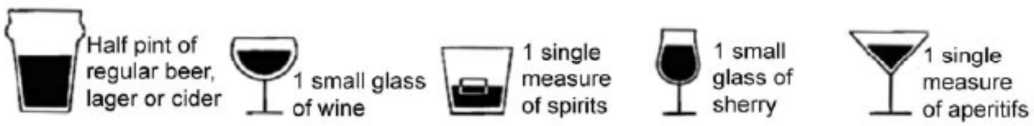
**National Data Opt-Out**

You can choose whether your confidential patient information is used for research and planning. You do not need to do anything if you are happy with how your confidential patient information is used. You can change your choice at any time. For more information or to opt-out, please visit: https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

| About You | | | |
|---|---|---|---|
| **Height** | | | |
| **Weight** | | | |
| **Waist Measurement** | | | |
| | | | |
| **Smoking Status** | **Never Smoked** | | |
| | **Ex-Smoker (please state quit date)** | | |
| | **Current Smoker** | | |
| **Smokers, what & how much do you smoke?** | **Cigarettes** | | /day |
| | **Cigars** | | /day |
| | **Pipe or Roll-Ups** | | Grams/Week |
| | | | |
| **Alcohol** | **Do you drink alcohol?** | Y | N |
| | **Do you drink wine?** | Y | N |
| | **Do you drink beer?** | Y | N |
| | **Do you drink spirits?** | Y | N |
| **How many units do you drink per week?** | | | |

| Fast Alcohol Screening Test Questions | Scoring System | | | | | Your Score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| **How often have you had 6 (women)/8 (men) or more drinks on a single occasion in the last year?** | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4+ times a week | |
| **How often during the last year have you been unable to remember what happened the night before because you had been drinking?** | Never | 1-3 | 4-6 | 7-9 | 10+ | |
| **How often during the last year have you failed to do what was normally expected from you because of drinking?** | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| **Has a relative, friend, doctor or healthcare professional been concerned about your drinking or suggested that you cut down?** | No | | Yes - not in the last year | | Yes – in the last year | |
| **Score** | | | | | | |

**This is one unit of alcohol**




**Each of these is more than one unit**

**Child (0-16) Health Questionnaire (Confidential)**

**Please print your answers clearly.**

| | | | |
|---|---|---|---|
| **Surname** | | | |
| **Forenames** | | | |
| **Address** | | | |
| | | | |
| | | | |
| | | | |
| **Postcode** | | | |
| **Date of Birth** | | **Gender** | Male / Female |
| **Telephone Number** | | | |
| | | | |
| **Parents** | | | |
| **Mother's Name** | | **Date of Birth** | |
| **Telephone Numbers** | | | |
| **Home** | **Work** | **Mobile** | |
| **Email Address** | | | |
| **Father's Name** | | **Date of Birth** | |
| **Telephone Numbers** | | | |
| **Home** | **Work** | **Mobile** | |
| **Email Address** | | | |
| | | | |
| **What is your ethnicity?** | | | |
| **British** | **Irish** | **African** | **Asian** | **Bangladeshi** |
| **Caribbean** | **Chinese** | **Indian/British Indian** | **Pakistani/British Pakistani** |
| **Other White (please state)** | | **Other Asian Background (please state)** | |
| **Other Black Background (please state)** | | **Other Mixed Background (please state)** | |
| **Other (please state)** | | **Not Stated** | |
| **Which language is the main language spoken at home?** | | | |
| **Is an interpreter needed?** | | | |
| | | | |
| **Which school/nursery is attended by the child?** | | | |

| Medical History | | |
|---|---|---|
| **Has your child had, or received treatment for, any of the following conditions?** | | |
| **Convulsions/Fits** | Y | N |
| **Asthma** | Y | N |
| **Diabetes** | Y | N |
| **Has your child ever had any other serious illness, injury or operation?** | Y | N |
| **If yes, please give details, including approximate dates:** | | |

| Medication | | | |
|---|---|---|---|
| **Does your child take any medicines?** | | Y | N |
| **Medication Name** | **Strength & Dosage** | **Frequency** | **When was this started?** |
| | | | |
| | | | |
| | | | |

| | | |
|---|---|---|
| **Does your child have an allergy to any medicines?** | Y | N |
| **Please specify** | | |
| **Does your child have any other allergies, e.g. peanuts, latex, bee stings?** | Y | N |
| **Please specify** | | |
| **Does your child have any sensory impairment or physical or learning disability?** | Y | N |
| **Please specify** | | |
| **Does your child have any ongoing medical/developmental problems?** | | |
| **Please specify** | | |

| **Immunisations** | **Date Given** | | |
|---|---|---|---|
| | **1st** | **2nd** | **3rd** |
| **BCG** | | | |
| **DTAP/IPV/HIB**<br>**Diptheria, Tetanus, Pertussis / Polio / HIB** | | | |
| **Pneumococcal PCV** | | | |
| **Rotavirus** | | | |
| **Meningitis B** | | | |
| **Meningitis C** | | | |
| **HIB/Men C** | | | |
| **MMR**<br>**Measles, Mumps, Rubella** | | | |
| **DTAP/IPV**<br>**Diptheria, Tetanus, Pertussis / Polio** | | | |
| **TD/IPV**<br>**Tetanus, Diptheria / Polio** | | | |
| **Hepatitis B** | | | |
| **Others** | | | |