

FISHER MEDICAL CENTRE
NEW PATIENT REGISTRATION FORM (GMS1)
PLEASE COMPLETE BOTH SIDES OF THIS FORM

PATIENT NO

ADMIN INITIAL/DATE

[] Mr [] Mrs [] Miss [] Ms [] Other [] Male [] Female

Surname..... First Name(s).....

Previous Surname(s).....

Date of Birth..... NHS Number (if known).....

Town and Country of Birth.....

Home

Address.....

Postcode..... Phone (landline & mobile).....

Occupation (last job if retired).....

Next of Kin: NoK / Contact phone No:

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

Your previous address in UK.....

..... Post Code.....

Name and address of your previous doctor while at that address.....

Are you from abroad or just returned from abroad? (ID required) - If Yes and previously registered in UK

Date you left UK..... Date of returning to UK.....

Previous address in UK.....

..... Post Code

If No: Date you first came to live in UK.....

If returning from the Armed Forces please state Service or Personnel Number and Enlistment Date

Ethnicity

- | | | |
|--|--|---|
| <input type="checkbox"/> British or mixed British | <input type="checkbox"/> Other Mixed Background | <input type="checkbox"/> Caribbean |
| <input type="checkbox"/> Irish | <input type="checkbox"/> Indian/British Indian | <input type="checkbox"/> African |
| <input type="checkbox"/> Other White Background | <input type="checkbox"/> Pakistani/British Pakistani | <input type="checkbox"/> Other Black Background |
| <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> Bangladeshi/British Bangladeshi | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> White and Black African | <input type="checkbox"/> Other Asian Background | <input type="checkbox"/> Other |
| <input type="checkbox"/> White and Asian | | <input type="checkbox"/> Ethnic category not stated |

First Language [] English [] Other (please state)

Date [] Signature of Patient [] Signature on behalf of Patient

Relationship to patient if signing on their behalf

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Please help us prepare for your 'New Patient Check' by completing the forms below.

UNITS



2



1.5



2



1



9

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits

Bottle of Wine

Alcohol Users Disorders Identification Test (AUDIT) C

Questions	Scoring System					Your Score
	0	1	2	3	4	
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	

Please circle your answers in the 'Scoring System' boxes above. The test will be scored by the Practice Nurse

Smoking * tick as appropriate

- | | |
|--|---|
| <p>*[] I have never smoked</p> <p>I used to smoke</p> <p>*[] Less than 1 per day</p> <p>*[] 1-9 per day</p> <p>*[] 10-19 per day</p> | <p>I still smoke</p> <p>*[] Cigarettes</p> <p>*[] Pipe</p> <p>*[] Cigars</p> <p>*[] Less than 1 per day</p> <p>*[] 1-9 per day</p> <p>*[] 10-19 per day</p> |
| <p>*[] 20-39 per day</p> <p>*[] 40 or more per day</p> | <p>*[] 20-39 per day</p> <p>*[] 40 or more per day</p> |