# SOHO SQUARE GENERAL PRACTICE

# PATIENT REGISTRATION FORM

*This form must be completed by all patients in conjunction with the GMS1 form*

## PATIENT INFORMATION

| | |
|---|---|
| TITLE | |
| FIRST NAME | |
| SECOND NAME | |
| GENDER | |
| DATE OF BIRTH (DD/MM/YYYY) | |
| EMAIL ADDRESS | |
| TELEPHONE – MOBILE OR OTHER | |

## PAST MEDICAL HISTORY

Do you have a current / past medical history of:

| | |
|---|---|
| HEART DISEASE | YES ☐ NO ☐ |
| STROKE | YES ☐ NO ☐ |
| DIABETES | YES ☐ NO ☐ |
| HIGH BLOOD PRESSURE | YES ☐ NO ☐ |
| CANCER | YES ☐ NO ☐ |
| ASTHMA/COPD | YES ☐ NO ☐ |
| OTHER SIGNIFICANT MEDICAL PROBLEM | YES ☐ NO ☐ |

## REGULAR PRESCRIBED MEDICATION

| | |
|---|---|
| Are you currently taking any medication? | YES ☐ NO ☐ |
| Do you take Warfarin or other anticoagulants? | YES ☐ NO ☐ |
| Do you take any drugs that suppress the immune system? | YES ☐ NO ☐ |
| Do you have any known allergies? | YES ☐ NO ☐ |
| Have you had the influenza vaccine this year? | YES ☐ NO ☐ |
| Have you had a pneumococcal vaccine? | YES ☐ NO ☐ |
| Do you smoke? | YES ☐ NO ☐ |
| Please provide a recent Blood Pressure reading – if you are able to? | ☐ / ☐ mmHg |

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## FURTHER PATIENT DETAILS

| | |
|---|---|
| Do you need an interpreter? | YES ☐ NO ☐ |
| *If yes, which language?* | |
| Are you housebound? | YES ☐ NO ☐ |
| Do you need help with mobility, speaking, hearing or have a diagnosed disability? | YES ☐ NO ☐ |
| Are you a carer? | YES ☐ NO ☐ |
| Do you have a carer? | YES ☐ NO ☐ |
| *If yes, please provide contact details?* | YES ☐ NO ☐ |

| | |
|---|---|
| Are you under the care of a Private GP? | YES ☐ NO ☐ |
| *If yes, do you want us to take care of your ongoing medical problems? (please detail)* | |
| *If yes, please detail any regular prescribed medication for your NHS records?* | |

| | |
|---|---|
| Can we use your mobile number to send appointment reminders and invitations? | YES ☐ NO ☐ |
| Can we use your email address to send our newsletters and communications from our PPG? | YES ☐ NO ☐ |

## PATIENTS UNDER 16 ONLY

| | |
|---|---|
| FORM COMPLETED BY | |

| | |
|---|---|
| Person with Legal Responsibility / Next of Kin | |
| NAME | |
| RELATIONSHIP TO CHILD | |
| HOME ADDRESS | |
| CONTACT EMAIL | |
| CONTACT TELEPHONE NUMBER | |

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| | |
|---|---|
| Other Person with Legal Responsibility / Next of Kin | |
| NAME | |
| RELATIONSHIP TO CHILD | |
| HOME ADDRESS | |
| CONTACT EMAIL | |
| CONTACT TELEPHONE NUMBER | |

| Please list the Full Name and Date of Birth of any other residents at the same home address who are registered with us | |
|---|---|
| NAME | DATE OF BIRTH (DD/MM/YYYY) |
| | |
| | |
| | |
| | |
| | |
| | |

| | |
|---|---|
| School / Nursery Details | |
| NAME | |
| ADDRESS | |

| | |
|---|---|
| Is the Child subject to a Child Protection Plan? | YES ☐ NO ■ |
| Does the Child have a social worker? | YES ☐ NO ■ |
| *If yes, please provide contact details:* | |

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