



CRICKLEWOOD HEALTH CENTRE

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 <input type="checkbox"/>	NO <input type="checkbox"/>
STROKE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
DIABETES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HIGH BLOOD PRESSURE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
CANCER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ASTHMA/COPD	YES <input type="checkbox"/>	NO <input type="checkbox"/>
OTHER SIGNIFICANT MEDICAL PROBLEM	YES <input type="checkbox"/>	NO <input type="checkbox"/>

REGULAR PRESCRIBED MEDICATION

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



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FURTHER PATIENT DETAILS

Do you need an interpreter?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>If yes, which language?</i>	
Are you housebound?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you need help with mobility, speaking, hearing or have a diagnosed disability?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you a carer?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you have a carer?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>If yes, please provide contact details?</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>

Are you under the care of a Private GP?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>If yes, do you want us to take care of your ongoing medical problems? (please detail)</i>	
<i>If yes, please detail any regular prescribed medication for your NHS records?</i>	

Can we use your mobile number to send appointment reminders and invitations?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Can we use your email address to send our newsletters and communications from our PPG?	YES <input type="checkbox"/> NO <input type="checkbox"/>

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 <input type="checkbox"/> NO <input type="checkbox"/>
Does the Child have a social worker?	YES <input type="checkbox"/> NO <input type="checkbox"/>
<i>If yes, please provide contact details:</i>	