

**Montpelier Surgery**  
**Under 16's Family Doctor Services Registration**

**GMS1**

**Please fill out all fields in BLOCK CAPITALS**

**Title** \_\_\_\_\_ **Surname** \_\_\_\_\_

**Date of Birth**

d	d	m	m	y	y
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**First Names** \_\_\_\_\_

**Town of Birth** \_\_\_\_\_

**Country of Birth** \_\_\_\_\_

**Current Address**

Flat No: (if applicable) \_\_\_\_\_ House Number \_\_\_\_\_ Postcode \_\_\_\_\_

Street Name \_\_\_\_\_ Telephone \_\_\_\_\_

**Please fill out this section as accurately as possible as we use it to locate your medical records**

**Your Previous Address**

**Postcode** \_\_\_\_\_

**Name and Address of Previous Doctor**

**If you are from abroad please give the date you first came to live in the UK.** \_\_\_/\_\_\_/\_\_\_

**Your NHS Number**

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**If Previous Resident in UK date of leaving**  
 \_\_\_/\_\_\_/\_\_\_

**And date returned to live in UK** \_\_\_/\_\_\_/\_\_\_

**School Details and Parent/Guardian Details**

**Parent's Name** \_\_\_\_\_ **Telephone Number** \_\_\_\_\_

**School Name** \_\_\_\_\_ **Address** \_\_\_\_\_

**Date Started at School** \_\_\_/\_\_\_/\_\_\_

**Additional Details**

**What is your main spoken Language?** \_\_\_\_\_ **Would you require an Interpreter? YES/NO**

**Next of Kin—Please give details of whom to contact on your behalf in an emergency.**

**Name** \_\_\_\_\_ **Relationship to you** \_\_\_\_\_

**Contact Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Are you currently taking any medication? If so please specify	
Do you have any allergies? Please give details	

## Medical and Family History

Please indicate below if you or a member of your family have suffered from any of the conditions listed below

Condition	You (Date of Diagnosis)	Family (Date of Diagnosis)
Heart Attack / Angina/ Other Chronic Heart Disease		
Heart Failure		
High Blood Pressure requiring medication		
Stroke ( ) Transient Ischaemic Attack ( )		
Diabetes: Type 1 ( ) Type 2 ( )		
Asthma requiring inhalers		
Chronic Obstructive Pulmonary Disease (COPD)		
Epilepsy		
Hypothyroidism		
Chronic Kidney Disease (Please indicate Stage 1-5)		
Depression requiring medication		
Schizophrenia/Bipolar/ other psychoses		
Cancer		
Dementia ( Alzheimer's / Parkinson's)		

Patient Signature \_\_\_\_\_

Signature On Behalf of Patient \_\_\_\_\_ Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

<b>For Office Use ONLY</b>	
<b>Proof of Identity:</b>	
British Passport valid and seen?	
EU Passport valid and seen?	
Other valid Passport seen and photocopied	
Proof of address within catchment area	
Offered New Patient Medical	
Patient informed of registration process	