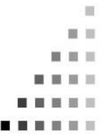
WELCOME TO THE ALMA PARTNERSHIP



To accurately register at the surgery, please complete this questionnaire and the purple GMS1 form in full. ALL new patients must provide photographic proof of ID (e.g. passport or UK driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college).

Today's date:	
SURNAME:	
FIRST NAME:	
DATE OF BIRTH:	
Occupation:	
Ethnicity:	☐ British ☐ African ☐ Bangladeshi ☐ Caribbean ☐Chinese ☐ Indian ☐ Irish ☐ Other White ☐Other Asian ☐Other Black ☐ Other Mixed ☐ White Asian ☐ Pakistani ☐ W&B African ☐ W&B Caribbean ☐ Refuse to divulge
Main Language:	☐ *Main language information refused*
Telephone number – Home:	
Telephone number – Work:	
Telephone number – Mobile:	
Email address *(we may contact you from time to time with practice information):*	

The practice may wish to contact you via email regarding your results, appointments or other medical related issues.

☐ ***I consent*** *to the Alma Partnership contacting me via email with confidential medical information*

☐ ***I do not*** *consent to the Alma Partnership contacting me via email with confidential medical information*

Have you been signed up to the *Electronic Prescription Service (EPS)* with a Pharmacy out of this area?	**YES / NO**	If you answered YES, we will need to change this once you are registered. Please inform a member of staff when handing back this paperwork.
Who is your next of kin?		
Relationship to you?		
Telephone no. of next of kin		

What is your height?		**What is your weight?**	
Are you a carer? *(i.e. do you look after a friend or family member who is ill, frail or disabled?)*		☐ Yes ☐ No	
Smoking Status:	☐ Never smoked ☐ Ex-smoker When did you stop smoking? ___________________ ☐ Smoker How many do you smoke a day? _______________		

MEDICATION:

Please list all the medication you are currently taking including the contraceptive pill. If possible, please provide a printout of your medications from your previous surgery and attach it to this sheet.

Name and strength	Dose

Please turn over……….

Please list any past illnesses and operations:

Date	Problem

Please list any allergies and describe their effect:

Date	Medicine/other substance	Effect

FAMILY HISTORY

Has any blood relative suffered from, before the age 60, any of the following?

Heart attack or angina Yes ☐ No ☐
Stroke Yes ☐ No ☐
Raised cholesterol Yes ☐ No ☐
Asthma Yes ☐ No ☐
Diabetes Yes ☐ No ☐
Cancer Yes ☐ No ☐ Type………………….. Relation……………….…………..

FEMALE PATIENTS ONLY:

Please let us know if you are pregnant – it is important we know this to arrange continuing antenatal care Are you pregnant? YES ☐ How many weeks? _______________	
When did you last have a cervical smear?	Approximate date _____________________

Summary Care Record – Your allergies and any medicines you are taking will automatically be uploaded to the NHS spine unless you ask us not to by completing a Summary Care Record opt out form available on request.

Care.Data - Information about you and the care you receive is shared, in a secure system, by healthcare staff to support your treatment and care. Information such as your postcode and NHS number, but not your name, will be used to link your records in a secure system, so your identity is protected. Information which does not reveal your identity can then be used by others, such as researchers and those planning health services. You will automatically be included in the Care.Data programme unless you complete an opt-out form which is available on request. Please see our leaflet and/or website for further information.

If any of the contact details on this form change in the future please inform us.

The practice runs a text message reminder service and by providing a mobile telephone number on this form you are consenting to be contacted in this manner. If you wish to opt out of this service, please notify a member of the reception team.

Patient Signature:_____________________________________ Date:_______________________

Please continue to the questionnaire overleaf.

Alcohol Consumption

As part of a Government initiative to address the issue of increasing alcohol consumption, we require all new patients to complete an alcohol consumption survey. Please use the unit guide to below to assist you when completing this questionnaire:

Your alcohol usage

Questions (please circle your answer)	Scoring system					Your score
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Scoring: *A total of 5+ indicates increasing or higher risk drinking*					**Total**	

If you score **5 or more** on the above questionnaire, please go on to complete the questionnaire overleaf, otherwise please hand your completed form to the receptionist.

UNITS

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits

Bottle of Wine

Questions (please circle your answer)	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what is expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt of regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes during the last year	
Has a relative/friend/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes during the last year	
					Total	

Scoring:
0-7 = Sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence

If you are concerned about the amount of alcohol you are consuming and would like to discuss this with your GP, please make an appointment at reception.