**NEW PATIENT HEALTH QUESTIONNAIRE**

To register with our Practice please complete this questionnaire. The information provided will allow the Doctor or Nurse to make an initial assessment of your health, which will help in your future treatment. If an alternative communication is required please speak to a member of staff. We make every effort to ensure that people who have a disability, impairment or sensory loss get information that they can access and understand.

**TODAYS DATE: …………………………………**

**Name: ……………………………………..……… Date of Birth: …….…………………..……………………..**

**Weight: …………………………………….…….. Height: ………….…………………………………………..….**

**Date of last Tetanus: ………………….……. Occupation: ……………………………………..……………**

**Do you smoke? Yes / No If yes how many per day? ……………………..……….**

**If you smoke how old were you when you started? ……………….**

**If you are an ex-smoker, how long ago did you stop? …………….**

**Would you like help to stop smoking? Yes/No**

**Do you take regular exercise? Yes / No how often? ……………………………….......................**

**If yes, please state which type: ……………………………………………………………………………………….…….……….**

**Do you have any allergies …………………………………………………………………………………………………..………….**

**Is there any other information about you that you would like us to know? ……………………………………………………………………………………………………………………………………….……..………**

**FAMILY HISTORY:**

**DIABETES YES/NO**

**HEART DISEASE YES / NO Family member?……………………………………….………..**

**(Heart attacks and Angina) Age when diagnosed……………………….………………….**

**STROKE YES / NO Family member? ………………………………………………..**

**CANCER YES / NO Family member? ……………….……………….………………**

**Age when diagnosed…………………………………………..**

**Which type of cancer? ………………………………………………………………………………………………………………………**

**CARERS:**

**Do you look after someone – a relative, friend or neighbour who is ill, frail or disabled and is unable to or has difficulty looking after themselves? Do you give support to someone who has mental health needs or misuses alcohol or drugs?**

**If you do, that means you are a carer and by registering that you are a carer with the Practice it could mean that we are able to offer you more support.**

**Please complete a Carer Registration form available from reception or as a downloaded from our website** [**www.hedmed.co.uk**](http://www.hedmed.co.uk)

**Do you have anyone who looks after you or your daily needs as a carer? YES / NO**

**Do you look after someone for his or her daily needs as a carer? YES / NO**

**(Excluding paid employment)**

**We welcome your feedback**

**Patients who would like to give us feedback can join our virtual Patient Participation Group by emailing us at meccg.hedingham**[**listens@nhs.net**](mailto:listens@nhs.net) **we will keep you informed on a regular basis. You can find us on Facebook and on Twitter @HedinghamCares**

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**Using the chart as a guide, please circle the appropriate answer to each question below.**

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|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **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 a month | 2/3 times a Week | 4+ times a week |  |
|  | | | | | | | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | | 7-9 | 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 |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in the last year | |  | Yes, during the last year |  |

**WE NEED YOUR CONSENT**

**CONTACT DETAILS: (Please remember to update us if there are any changes to your details).**

**We only share information that can identify you with those directly involved in your NHS care, those who have a legal right to it and those you have given us permission to share it with. We share clinical data with other NHS organisations that only access it when needed, i.e. when attending Hospital appointments. I give consent for my information to be shared. Please tick the box**

**Please visit www.hscic.gov.uk/scr/patients for more information.**

**Please note that by providing the following details you are agreeing to be contacted by telephone, *SMS* text messaging or email. Providing a mobile telephone number will enable us to send *SMS* text messages and appointment reminders.**

**There may be occasions where we need to leave a message on your answerphone. If you are happy for appointment reminders and *SMS* text messages to be sent to your mobile telephone. Please tick the box**

**Home Telephone: ……………………..………………. Mobile: …………………………………………………....**

**Work Telephone: ………………………………………. Other: ………………………………………………..……..**

**Email: ……………………………………………………….………………………………………………………………………………..……….**

**(Please write clearly).**

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**Patient Access allows you to book appointments, order your repeat prescriptions, view recent test results and your vaccination record. (16 years and over)**

**If you would like us to proceed with Patient Access and you will be sent an email with your unique identification and a linkage key so you can create a password. Please tick the box**

**I GIVE CONSENT FOR THE BELOW NAMED PERSON TO DISCUSS:**

**Name…………………………..………… Relationship………………………… Telephone Number………………………..………..**

**Full Medical Records Results only**

**Signature………………………………………………………….. Print Name……………………………………………………………………**

**Thank you for completing this questionnaire. We very much look forward to meeting you at your new patient check appointment. Please note that your named accountable GP will be Dr @ Hedingham Medical Centre.**

**PATIENTS SIGNATURE……………………………………………. DATE…………………………………………**

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