HEDINGHAM MEDICAL CENTRE

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.

Please select your preferred "Home" site: **Castle Hedingham** ☐ **Sible Hedingham** ☐

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

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 ☐

This Practice's preferred method of contacting you is by *SMS.* Please tick the box if you are happy with this.

Please tick the box ☐

First names: …… **Surname: ……**

Date of Birth: ……

Home Telephone: …… **Mobile: ……**

Work Telephone: …… **Other: ……**

Address……

…… Postcode……

Email: ……

(Please write clearly).

10 Falcon Square, Castle Hedingham, Essex, CO9 3BY
T: 01787 461 465 w: hedmed.co.uk e: meccg.thecastlesurgery@nhs.net

Dr W Littler • Dr R Silcox • Dr C Davies • Dr K Lethaby

ABOUT YOU:

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? ……

WE WELCOME YOUR FEEDBACK:

Patients who would like to give us feedback can join our virtual Patient Participation Group by emailing us at meccg.hedinghamlistens@nhs.net we will keep you informed on a regular basis. You can find us on Facebook and on Twitter @HedinghamCares

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

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)

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

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

I GIVE CONSENT FOR THE BELOW NAMED PERSON TO DISCUSS:

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

Full Medical Records ☐ **Results only** ☐

Theses instructions are valid from Today's date …….. Until……..
(Please specify end date). If none specified, the Surgery will accept this as permanent instruction.

Signature…….. Print Name……

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.

Patient Access

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 you will be sent an email with your unique identification and a linkage key so you can create a password. Please tick the box ☐

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 A T Hedingham Pooled List.

PATIENTS SIGNATURE…….. DATE……

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations (Amendment) Act 2000.

Please indicate your ethnic origin. This is not compulsory but may help with your healthcare as some health problems are more common to specific communities, and knowing your origin may help with the early identification of some condition.

Please choose one section from A-E and tick the appropriate box.

A	**WHITE**	British	☐
		Irish	☐
		Other (please specify)……..	
B	**MIXED**	White & Black Caribbean	☐
		White and Black African	☐
		White & Asian	☐
		Other (please specify)……	
C	**ASIAN OR**	Indian	☐
	ASIAN BRITISH	Pakistani	☐
		Bangladeshi	☐
		Other (please specify)……	
D	**BLACK OR**	Caribbean	☐
	BLACK BRITISH	African	☐
		Other (please specify)…….	
E	**CHINESE OR**	Chinese	☐
	OTHER ETHNIC	Any Other Origin (please specify)…….	
		……..	

NEXT OF KIN:

First Names: …….. **Surname: ……..**

Date of Birth: …… **Relationship to you ……**

Address: ……

…… **Postcode: ……**

Home telephone: …… **Mobile: ……**

NHS
Mid Essex
Clinical Commissioning Group

Are you living with anxiety, stress or worry?

Have problems sleeping, feel sad, worried or anxious?

We offer supported online programmes to help you take charge and improve your quality of life.

No GP referral is needed, access whenever suits you.

We want everyone in mid Essex to livewell

To find out more visit

me.silvercloudhealth.com/signup