FAMILY HISTORY

HAVE ANY OF YOUR BLOOD RELATIVES
HAD THE FOLLOWING AND AT WHAT AGE?

HEART ATTACK

ANGINA

HIGH BLOOD PRESSURE

DIABETES

CANCER (BOWEL, BREAST, OVARY ETC)

ASTHMA

GLAUCOMA

STROKE

ANY OTHER SERIOUS ILLNESS

WOMEN - ONLY

ARE YOU CURRENTLY PREGNANT?.....
HOW MANY CHILDREN DO YOU HAVE? ……
PLEASE LIST THEIR DATE OF BIRTH

HAVE YOU HAD A HYSTERECTOMY?
YES/NO DATE:…….

Thank you for taking the time to share this valuable information with us, it will only be used for the purpose it was intended.

Preferred method of contact tick below

SMS …….

Telephone …….

Email ……

Letter……..

If you have repeat prescriptions please nominate a pharmacy of your choice so we can send your prescription electronically.

……...

Identification Checked
Photo ID ☐
POA ☐
Date……

Chapelthorpe Medical Centre
New Patient Health Check

Please complete this form and hand it to reception with photo ID and proof of address

TITLE: MR / MRS / MISS
MASTER / MS

DATE OF BIRTH:……

SURNAME:……

FIRST NAMES (S)……

FULL ADDRESS:
……..
……
……
Post code……..

TEL: NO:……

MOBILE:……..

EMAIL ADDRESS ……..

OCCUPATION:……

PLEASE CIRCLE AS APPROPRIATE

Do you have a disability? Yes or No

Physical Learning Disability/Difficulty

Sight problems Hearing problems

Speech problems Mental Health Condition

Other please specifiy:_____

Do you need written communication ? Yes or No

Large Print Email/SMS Easy Read

Do you need any verbal/Face to Face communication? Yes or No

BSL Interpreter Foreign Language Interpreter

Hearing Loop Non-Verbal Communication

Do you have a carer? Yes or No

Please specify any requirements you have regarding your disability when accessing our service:

PLEASE CIRCLE AS APPROPRIATE

Nationality

A **White**. ڤ
B **Mixed**.
C **Asian or Asian British**
D **Black or Black British**
E **Chinese or other ethnic group**.

Have you read the Summary Care Record information given to you with this form? ……

Do you wish to OPT OUT? …….
If you wish to opt out complete the form and return it to us.

PLEASE LIST ANY ALLERGIES YOU HAVE?

SMOKING SCREENING

Do you smoke YES/NO

If YES how many? ……..DAILY

Have you ever smoked? YES/NO

If stopped smoking when? Date ……

There is major health problems associated with smoking and we are committed to help our patients give up smoking should they wish to do so.
There is expert advice available and they are also able to prescribe medication to assist the process should you wish to take advantage of the Quit Smoking Service, please If you smoke we strongly advise that you stop. We <u>can</u> help you. Should you wish to take advantage of the Quit Smoking Service, please call: **01924 252174** or visit their website: **www.wakefield.yorkshiresmokefree.nhs.uk/**

Advice given ☐

ALCOHOL SCREENING

How much alcohol do you consume weekly?.....(see units below)
175ml White wine = 2 units approx
175ml Red wine = 2 units approx
1 Pint 4% Beer = 2.3 units approx
1 Pint 5% Lager = 2.8 units approx
1 Pint 4% Cider = 2.3 units approx
35ml 40% Spirit = 1.4 units

How often do you have a drink that contains alcohol?

Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking?

1 - 2	3 – 4	5 – 6	7 - 9	10+

How often do you have 6 or more standard drinks on one occasion?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily

GENERAL SCREENING

What is your:

HEIGHT ……

WEIGHT ……...

WAIST……(Measure at tummy button level)

How would you describe your diet?

GOOD	**AVERAGE**	**POOR**

OTHER ☐ Please State …….

Exercise

No exercise	Little exercise	Exercises regularly	Unable to exercise