Identification Checked
Photo ID ☐
POA ☐
Date……..

Chapelthorpe Medical Centre
New Patient Health Check

Please complete this form and hand it to reception with some form of ID (proof of person)

TITLE: MISS /MASTER

DATE OF BIRTH:……

SURNAME:……

FIRST NAMES (S)……

FULL ADDRESS:
……..

……

……

Post code……..

TEL: NO:…….

MOBILE:……..

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

…….....

PLEASE CIRCLE AS APPROPRIATE

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

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:

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?

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

Preferred method of contact tick below

SMS …….

Telephone …….

Email ……

Letter……..