In order to register with a GP Practice, you are now required to produce two documents as proof of identity.
Please provide one document from the following list:

OFFICE USE ONLY

	Checked	Signed
▪ Passport		
▪ Driving Licence		
▪ Official Identity Card		
▪ Birth Certificate		
▪ Marriage Certificate		

Plus one item from the following list, as proof of address:

OFFICE USE ONLY

	Checked	Signed
▪ Tenancy Agreement		
▪ Council Tax Bill		
▪ Utility Bill		
▪ Wage Slip		
▪ Other_______________		

We thank you for your time and hope that with this information we will be able to help you lead a healthier life.

Dr Andrew Blackburn
Dr Alison Shaw
Dr Claire Tickner
Dr Jessa Morton
Dr Peter Birtles
Dr Charlotte Groom

Wadhurst Medical Group (Incorporating Belmont & Ticehurst Surgeries)
St James's Square Wadhurst TN5 6BJ
Tel: 01892 782121
Appointments: 01892 783888

hwlhccg.belmont@nhs.net
www.wadhurstmedicalgroup.co.uk

NEW PATIENT QUESTIONNAIRE — NOV 2019

Welcome to our practice! In order to help us give you the best medical care, please complete this questionnaire. Your answers are confidential, as are all medical records. As a new patient in this practice, you are invited to have a health check. This involves a few simple tests (height, weight, blood pressure and urine check) with your doctor or a Practice Nurse. You will need to make an appointment for this and also PLEASE BRING A URINE SPECIMEN* with you when you come. Even if you do not have a health check, please let us have this completed questionnaire. *Ask at reception for a urine sample bottle

SURNAME…………………………………… **FORENAME(S)**……………………………………

…………………………………………………… ……………………………………………………………

DATE OF BIRTH……………………………….

TEL……………………………………………… **MOBILE**…………………………………………

ADDRESS…………………………………………………………………………………………………

……..

……………………………………………….. **POSTCODE**…………………………………….

OCCUPATION……………………………………………………………………………………….

SPOKEN LANGUAGE……………………………………..**INTERPRETER REQUIRED: Y/N**

STATUS (Married / Single etc)……………………………………………………………………

NEXT OF KIN……………………………………………………………………………………………..

NAMES OF PERSONS WHO LIVE WITH YOU…………………………………………………

……

DOCTOR YOU ARE REGISTERING WITH…………………………………………………………

I understand that my named GP will be the same as my registered Doctor — **Yes** ☐

DATE……………………………………… **SIGNED:**………………………………………

WEIGHT HEIGHT

ALCOHOL

How many units of alcohol do you drink per day?..............................

(1 unit = ½ Pint of beer / very small glass of wine)

- 1-2 units a day ☐
- 3-6 units a day ☐
- 7-9 units a day ☐
- Over 9 units a day ☐

FAST ALCOHOL SCREENING TEST

Please complete the following questionnaire. Please make an appointment with your doctor if your score is 3 or above as this suggests hazardous or harmful drinking.

Questions	Scoring System					
	0	1	2	3	4	Score
How often do you have 8 (men)/6(women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
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 failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/ 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	

SUMMARY CARE RECORD

Yes No

I would like to opt into this service which allows access to my electronic health record when I need urgent treatment by someone other than my own GP. ☐ ☐

Please refer to the enclosed leaflets for further information about this service.

ONLINE SERVICES

Yes No

I would like to register for one or all of the Online Services and I have completed the request form; I am aged 13 years or over. ☐ ☐

SMS TEXT MESSAGING SERVICE

Yes No

If you have provided your mobile telephone number you are able to receive SMS Text Messages relating to your direct care e.g. appointment reminders, annual review reminders etc. are you happy to receive these notifications? ☐ ☐

Yes No

From time to time we may send you text messages about issues other than your direct care e.g. requesting feedback for the Practice or news relating to the Practice. Are you happy to receive these notifications? ☐ ☐

ACCESSIBLE INFORMATION:

We would like to record your preferred method of communication so that you can receive your health information in a format you can access and understand. For most of us our preferred method of contact is our home telephone number or mobile number but for example, If you are hard of hearing that may not be suitable for you.
Please let us know if you require information in a large print or easy read format, or in braille; or if you need a British Sign Language/Sign Language or Foreign Language interpreter or advocate during your appointments; or if we can support you to lip-read or use a hearing aid communication tool.
If you or someone you are caring for wishes us to contact you in another way other than by telephone, please do complete some details below or speak to a Receptionist or the Practice Manager at your Surgery. We will then record your needs by highlighting it in your medical records. Otherwise we assume that you are happy for us to contact you by telephone or letter.
I would like information in a different format, details below

……

SMOKING

Never smoked ☐

Ex Smoker: Date stopped and approx. no. smoked a day: ☐

…………………………………………………………………………………………

Smoker – Number smoked per day:

- 1-9 a day ☐
- 10-19 a day ☐
- 20-39 a day ☐
- Over 40 a day ☐

EXERCISE:

Do you exercise at least three times a week for more than 20 minutes (or equivalent)? Yes ☐ No ☐

BLOOD PRESSURE:

Have you had your blood pressure checked in the past three years? (Let us arrange this for you if not) Yes ☐ No ☐

ETHNIC GROUP:

Please indicate the ethnic group you feel you belong to below, e.g. White British; White Irish; White Any other White background; Asian or Asian British; Black or Black British; Mixed White and Black Caribbean/Black African/Asian; Chinese; Other ethnic group, etc. If you do not wish to complete this information please say “Not Stated” below.

………

FAMILY HISTORY:

Have any of your Parents, Grandparents, Siblings, Aunts / Uncles had a serious illness. Yes ☐ No ☐

Please give details……………………………………………………………….

………………………………………………………………………………………

DO YOU HAVE A CARER?

If yes, please give Carer details below: Yes ☐ No ☐

Name……………………………………………………………………………………

Tel / Mobile Contact Details:……………………………………………….

………………………………………………………………………………………

ARE YOU A CARER?

Yes ☐ No ☐

A carer is a person who looks after someone at home because of their relationship with that person. A carer may be a relative/friend or neighbour and does not always live with the person cared for. A carer is not paid for the care that they provide.

Do you agree to being referred to care for the carers? Yes ☐ No ☐

YOUR MEDICAL HISTORY: Please provide details below or use an extra sheet if necessary:

	Yes	No
Any serious illnesses?	☐	☐
Any operations?	☐	☐
Any allergies?	☐	☐
Any medication taken? (Please list):	☐	☐

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

PRESCRIPTIONS: Wadhurst Medical Group can send prescriptions via an electronic system to your designated pharmacy. Would you like to sign up to the Electronic Prescription Service (EPS)? If yes, please state the name and address of your **designated pharmacy** below and sign the declaration:

Yes ☐ No ☐

……………………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

I confirm I am happy for Wadhurst Medical Group to send my prescriptions via EPS.

Signed:……………………………………………………………………………

Date:………………………………………………………………………………

WOMEN ONLY:

When did you last have a cervical smear test?...

Do you have an intra uterine device/coil/IUD/IUS/Mirena? If so, which type and when was it inserted?

……………………………………………………………………………………………………