Cloughmore medical centre/canolfan feddygol

NEW PATIENT REGISTRATION HEALTH QUESTIONNAIRE

(all information supplied will be recorded in your confidential medical records)

Patient Data:

Surname: ………………………………………… Forename(s): ……………………………………………….

Date of Birth: ………………………….. Marital status: …………………………………………..

Home tel: ……………………………… Mobile (if aged 16 and over): ………………………….

Email address: ……………………………………………………………………………………………

Ethnicity: …………………………………… Gender: ……………………………………………………

Language preference English / Welsh (*please delete as appropriate)*

Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, to let you know that your prescription or your sick note is ready for collection and anything else relevant to your healthcare? **Yes/ No**

Lifestyle Data:

Smoking

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

Have you ever Smoked? Yes / No If yes, when did you stop?...

What do you smoke? Cigarettes/Cigars/Pipe

Would you like advice on how to give up smoking? Yes/ No

Alcohol:

A 750ml bottle of wine contains 10 units
A standard (175ml) glass of wine contains 2 units
A single small shot of spirits (25ml) contains 1 unit
A standard 70cl bottle of spirits contains 28 units
A pint of 3.6% strength lager/beer/cider contains 2 units
A pint of 5.2% strength lager/beer/cider contains 3 units

How many units of alcohol do you drink a week?

………………………………

Follow the link below to access more information including a guide to calculating your alcohol intake:
https://www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units/

Height and Weight:

Please tell us your most recent measurements for the following (if known), *if not please use the machine in reception and we can attach the slip to your registration form:*

Height: ………………… Weight: ……………… Bloods Pressure: …………..

☐ ***If you do not want information to help with weight management and alcohol status, please tick box.***

Medical data

NB: The following information you supply may assist us to provide good care for you whilst we wait for your previous medical records.

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease? *Yes* / *No* which family member? ………………………….
Stroke? *Yes* / *No* which family member? ………………………….
Cancer? *Yes* / *No* which family member? ………………………….
Site of cancer? ……………………………………………………………………………….

Medication

Please give details of any medication which you take (prescribed or otherwise):

………
………
Please attach or forward us your most recent repeat medication slip if you have one.

Allergies

Do you have any allergies? *Yes*/*No*

If *Yes*, please give details:

…………………………………………………………………………………………………

Additional Needs

Asylum seeker: Yes/No. Refugee: Yes/No. Student: and or further education Yes/No.

Carers:
Are you a carer? Yes/No If yes, who do you care for e.g. grandchild, husband, wife or other:
………
Do you have a carer? Yes/No If yes, please provide their name and number:
………
Would you like more information on help available to carers? Yes/No

Military Veteran:
Have you ever served in the Armed Forces? Yes/No

Mobility/ Disabilities:
How would you describe your mobility?
Able Bodied/ Needs Assistance e.g., Waling Stick or Zimmer Frame/ Wheelchair Bound.

Any Disabilities? E.g., Registered Blind, Deaf: ……………………………………………………………

For Female Patients:
Have you had any children: Yes/No If Yes how many and ages? ______________________

When was your last smear? ________________

Thank you for completing this questionnaire.