NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

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

Forename: ………………………………………Surname: ……………………………………

NHS number (if known): ............................................................................

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

Address: ………………………………………………………………………………………………

……………………………………………………………….…………Postcode: ....………….….

Home Tel: …………………………………………. Mobile: …………………………………

Ethnicity: ………………………………………………………………………………………………

Gender: ……………………………………………………………………………………………….

**Emergency contact details** (name & number):…………………………………………….

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

**Do you require a translator?** Yes/No

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**

We have an electronic method of contact available for patients to contact the surgery for non-urgent requests – do you consent for us to correspond with you via this method and supply us with a preferred e-mail address for this purpose? **Yes/No**

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

**Are you a student?** Yes/No **Course & duration**:…………………………….……………

**Smoking**

Do you smoke? **Yes / No** If Yes, how many cigarettes per day ………………….

**Alcohol**

How many units of alcohol do you drink a week? ………………………………

**Height and Weight**

Height: ……………………….

Weight: ……………………….

*Please note, we may contact you to offer you support or advice if appropriate based on your submission.*

**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):

|  |  |
| --- | --- |
| **Name of drug** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

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:

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

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

**Past Medical History**

Please give details of any treatments/medical conditions:

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

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

**Carers**

Do you need/have anyone who looks after you or your daily needs as Carer? **Yes/No**

Do you care for anyone else? **Yes/No**

*(*If yes, *please ask the reception staff about Carers support)*

**Asylum Seeker Yes/No**

**Military Veteran**

Have you ever served in the Armed Forces?  **Yes/No**

**Communication**

Do you have any communication/information needs relating to sensory loss and, if so, what are they and how would you like us to communicate with you?

**…………………………………………………………………………………………………………………**

***Thank you for completing this questionnaire.***