Cathays Surgery - New Patient Health Forms (ADULT)

Please complete as accurately as you can and return to the practice

Identification & Contact Details

Forename (s):		Date of birth:	(dd/mm/yyyy)
Surname:		Gender:	
Town/Country of birth:		Will you require a translator support during appointments?	Yes / No
Main lanugage spoken:			
Home phone number:		Mobile phone number:	
Email address:		Preferred method of contact:	Phone / SMS / Email
Are you happy for us to send you health-related marketing text messages or emails? We may occasionally wish to send you invitations to clinics and other health care services that we feel would be beneficial to you and your health, such as flu vaccines. This is now being classed as marketing. **Be assured, we will NEVER share your details to a non-NHS third-party organisation for marketing purposes.**			Yes / No
Would you like to be signed up to our MyHealthOnline service? This service allows you to order repeat prescriptions online. If yes, we will send you your MHOL sign-up details shortly after we complete your surgery registration.			Yes / No
Emergency Contact Name:			
Their relationship to you:		Their phone number:	

Do you have any children? If yes, please provide their details. If they are registered or registering at Cathays Surgery too, please let us know so we can link them to your records.	Name	Boy / Girl	Age	Also registered here?
				Yes / No
				Yes / No
				Yes / No

Lifestyle Questions

Occupation:			
Are you a student?	Yes / No	If yes, what are you studying and when does your course end?	Course Subject: _____ End Date: _____ Month & Year
Are you an asylum seeker/refugee?	Yes / No	Are you a veteran?	Yes / No
What is your marital status?	Single / married / divorced / widowed	Who do you live with?	Alone / family or flatmates / homeless

Health Screening Questions

Height		Weight	
Do you exercise regularly?	Yes / No	_____ times a week	cardio / strength / yoga / other _____
Have you had cervical screening/ smear test?	Yes / No	Women ages 25 and over should have a smear test every 3 years. If you have not had one recently, please contact us to book an appointment.	
Do you smoke?	Yes / Have never / Used to	_____ cigarettes a day	When did you start? _____ When did you stop?_____
Would you like advice on how to stop smoking?	Yes / No	Our local pharmacy Woodville Pharmacy provides a FREE smoking cessation service. If you are looking to quit smoking, please contact them on **02920 227835**. Further information and support links can be found our website page **'Unhealthy Habits'**	
Do you drink alcohol?	Yes / Have never / Used to	_____ units a week	When did you start? _____ When did you stop?_____
Would you like advice on reducing your alcohol intake?	Yes / No	If you drink more than 14 units (women) or 21 units (men), you may want to consider reducing your intake. Contact us if you would like to discuss this with one of our clinicians. Further information and support links can be found our website page **'Unhealthy Habits'**	

Turn the page to continue...

Health Screening Questions continued...

Have you ever missused drugs or taken drugs recreationally? This could include recreational drug use, addiction, legal and/or illegal drugs	Yes / Have never / Used to What drug(s)? _____ When did you start? _____ When did you stop?_____	If you would like to discuss drug misuse or recreational drug use with one of the clinicians, please contact us. Further information and support links can be found our website page **'Unhealthy Habits'**

Medical History

Do you have any allergies that you are aware of?	Yes / No - If yes, please give details below.		
	Allergy to - e.g. foods, drugs, animals etc.	Type of reaction - e.g. rash, swelling etc.	Severity

Have you EVER suffered from the following? - if yes, please tick the appropriate box and add the date you suffered from the condition.			
☐ - Heart Attack _____	☐ - Epilepsy _____	☐ - Diabetes _____	☐ - Depression _____
☐ - Angina _____	☐ - Thyroid Disorder _____	☐ - Emphysema / COPD _____	☐ - Anxiety _____
☐ - Stroke _____	☐ - Cancer _____	☐ - Dementia _____	☐ - Other Mental Health _____
☐ - High Blood Pressure _____	☐ - Asthma _____	☐ - Tuberculosis (TB) _____	☐ - Jaundice _____
☐ - Skin Disease _____	☐ - Stomach Ulcers _____	☐ - Kidney Disease _____	☐ - Hayfever _____
☐ - Malaria _____	Please give details of any other significant illnesses or operations you have had here _____		
Do you have a family history of any illnesses? If yes, please give details.	_____ _____		

Have you ever been tested for the following?			
Hepatitis B	Yes / No	Positive / Negative	Date: _____
Hepatitis C	Yes / No	Positive / Negative	Date: _____
HIV	Yes / No	Positive / Negative	Date: _____

Do you have any disabilities? - if yes, please tick the appropriate box and add the date you suffered from the condition.			
☐ - Impaired Hearing/Deaf _____	☐ - Speech Impaired _____	☐ - Partially Sighted/Blind_____	☐ - Mobility Impaired _____
☐ - Learning Disabilities _____	☐ - Other, please give details _____		

Support

Do you require any specific support? - if yes, please give details of what support you require.	Yes / No	_____ _____
Do you have a carer? - If yes, please provide their details.	Yes / No	Your carer's name: _____ Your carer's phone number: _____
Are you a carer for someone else?	Yes / No	Who do you care for?: _____ Are they registered as a patient here?: Yes / No

Immunisations

Have you had the following immunisations/vaccines?	
☐ - ACWY Meningitis Date: _____	☐ - MMR Booster (Measles, Mumps, Rubella) Date: _____
☐ - BCG/HEAF test Date: _____ Do you have a BCG scar? Yes / No	☐ - Covid-19 Date of 1st dose: _____ Date of 2nd dose: _____

Thank you for completing this form!