Dear Sir/Madam

As a newly registered patient with this practice, we would ask you to complete the attached questionnaire alongside the registration form.

**If you need repeat medication,**please bring a copy of your **re-order slip** from your previous GP or if you don’t have one, please ask your previous surgery to **email or fax a printout of your medication** to us on 01938 810955. This will help us to supply you with the correct medication in a timely manner. Repeat medication will take at least 3 working days to process from when we have all the details.

Yours faithfully

Dyfi Valley Health

**NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE**

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

Title:…………………………………………………………………………………………........

Surname: …………………………………………………………………………………………………

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

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

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

Town and Country of Birth:……………………………………………………………………………...

Address: ………………………………………………………………………………………………….

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

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

Ethnicity: ……………………………………………………………………………………………….

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

*Next of Kin:*

*Name:……………………………………………..……Relationship:…………………………………*

*Address:……………………………………………………………………………………..*

*Contact Telephone number:…………………………………………………………………*

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 (please delete as appropriate)**

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 (please delete as appropriate)**

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

**Smoking**

Do you smoke? *Yes* / *No*

If *yes*, how many: Cigarettes per day ……. Ounces of tobacco per day …….

**Alcohol**

For the following questions please answer to the best of your knowledge: We have provided a basic guide to alcohol content below to assist your completion:

*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*

Follow the link below to access more information including a guide to calculating your alcohol intake - Alcohol units - NHS (www.nhs.uk)

Or you can use Alcohol Change’s calculator - [Unit calculator | Alcohol Change UK](https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator)

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

**Height and Weight**

Please tell us your most recent measurements for the following (if known)

**Height: ……………………….. Weight: ……………………….**

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

***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):

|  |  |
| --- | --- |
| **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:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

**Immunisations – please tick if you have been immunised against the following illnesses, and if possible please give the dates of the latest vaccinations:**

Diphtheria □ \_\_\_/\_\_\_/\_\_\_\_\_

Measles □ \_\_\_/\_\_\_/\_\_\_\_\_

Polio □ \_\_\_/\_\_\_/\_\_\_\_\_

Smallpox □ \_\_\_/\_\_\_/\_\_\_\_\_

Tetanus □ \_\_\_/\_\_\_/\_\_\_\_\_

Influenza □ \_\_\_/\_\_\_/\_\_\_\_\_

Whooping cough □ \_\_\_/\_\_\_/\_\_\_\_\_

German Measles □ \_\_\_/\_\_\_/\_\_\_\_\_

Tuberculosis □ \_\_\_/\_\_\_/\_\_\_\_\_

Typhoid Fever □ \_\_\_/\_\_\_/\_\_\_\_\_

Swine Flu □ \_\_\_/\_\_\_/\_\_\_\_\_

**Have you ever suffered from? (Please tick as appropriate)**

Epilepsy □Yes □No

Blindness/Glaucoma □Yes □No

High Blood Pressure □Yes □No

Diabetes □Yes □No

Heart Attack/Stroke □Yes □No

Depression □Yes □No

Cancer □Yes □No

Asthma □Yes □No

Eczema/Hay Fever □Yes □No

COPD □Yes □No

Have you ever had a cervical smear? □Yes □No

If yes – please state the date of the most recent \_\_\_/\_\_\_/\_\_\_\_\_

**Carers**

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

If *yes*, would you like them to deal with your health affairs here? *Yes*/*No*

*(A member of reception staff can help with these arrangements)*

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

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

**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?

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

**Ethnic Group:**

White – British □ Irish □ Other□\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Black – Caribbean □ African □ Other □\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asian – Indian □ Pakistani □ Chinese □ Other □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mixed – White & Black Caribbean □ White & Black African □

White & Asian □ Other □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and Address of Previous GP:** *(we will request a brief history from your Practice, so we have your up to date details)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any serious illness/operations/accidents/disabilities and/or any pregnancy related problems, and the year they took place:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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