

# Tenby Surgery

## Y Meddygfa Dinbych-y-Pysgod

### NEW PATIENT REGISTRATION HEALTH QUESTIONNAIRE

As part of our registration procedure, you are required to complete a registration form and the new patient registration health questionnaire and attend a consultation with the Health Care Assistant, which will include a short medical examination. Please return the completed forms to reception.

#### Personal details:

Surname:

First Name(s):

NHS number:

D.O.B.

Marital Status:

Address:

Postcode:

Home phone number:

Mobile phone number:

Email address:

Gender:

Ethnicity:

#### White

- Welsh
- English
- Scottish
- Northern Irish
- British

#### Asian, Asian Welsh or Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

#### Black, Black Welsh, Black British, Caribbean or African

- Caribbean
- African
- Any other Black, Black British or Caribbean background

#### Mixed or multiple ethnic groups

- White & Black Caribbean
- White & Black African
- White & Asian
- Any other mixed or multiple ethnic background

#### Other ethnic groups

- Arab
- Any other ethnic group

**Emergency contact details: these contacts will only be used in case of an emergency**

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Name of next of kin

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Contact number

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Relationship to patient

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Other emergency contacts

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Name

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Contact number

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Relationship to patient

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Language Preference: Please select one

**WELSH**

**ENGLISH**

**OTHER**   
please specify

**Consent to contact electronically/text**

Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, let you know that your prescription or sick note is ready for collection and anything else relevant to your healthcare? (please select)

**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 email address for this purpose? (please select)

**Yes**

**No**

**Lifestyle:**

SMOKING

Do you smoke?

**Yes**

**No**

**Ex smoker**

If yes-

Cigarettes per day \_\_\_\_\_

or

Ounces of tobacco per day \_\_\_\_\_

Do you vape?

**Yes**

**No**

**Ex vape user**

Do you use chewing tobacco?

Yes

No

Ex user of chewing tobacco

### ALCOHOL

Answer the following questions the best you can, to the best of your knowledge.

Below is a simple guide to how much alcohol different drinks contain to help you give an answer:

<b>750ml bottle of wine</b>	<b>10 units</b>
<b>175ml(standard) glass of wine</b>	<b>2 units</b>
<b>25ml(single) shot of spirits</b>	<b>1 unit</b>
<b>70cl(standard) bottle of spirits</b>	<b>28 units</b>
<b>Pint of 3.6% lager/beer/cider</b>	<b>2 units</b>
<b>Pint of 5.2% lager/beer/cider</b>	<b>3 units</b>

Follow the link below for more information, including a guide to calculate your alcohol consumption [Alcohol units - NHS](#) –Or you can use an Alcohol Change ledger

– [Unit accountant | Alcohol Change UK](#)

How many units of alcohol do you drink each week? \_\_\_\_

### HEIGHT AND WEIGHT

Height

Weight

### EXERCISE

What is your level of exercise?

Inactive

Gentle

Moderate

Active

*Note: We may contact you to offer support or advice, if appropriate, based on your replies.*

### DIET

Do you follow a special diet?

Yes

No

If yes, what diet?

### **Medical history: Please indicate as appropriate**

Note: The following information you provide us with may help us provide you with good care as we await your previous medical records.

Are you diabetic?

Yes

No

Diet Control  Tablets  Insulin

Are you Asthmatic?

Yes

No

Do you have COAD (Chronic obstructive airway disease)?

Yes

No

Do you have heart disease?

Yes

No

Do you have high blood pressure?

Yes

No

Do you have epilepsy?

Yes

No

Have you had a stroke?

Yes

No

Date of stroke?

Do you have thyroid problems?

Yes

No

Hyperthyroid  Hypothyroid

Have you had cancer/tumors?

Yes

No

If please specify:

Have you received a blood transfusion prior to 1996?

Yes

No

Are you currently under the care of a specialist consultant or undergoing specialist treatment?

Yes

No

If yes, please provide information

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**Medication:**

Please list all repeat medications and attach your repeat list from your previous doctors to this form.

*N.B. Please ensure that you have a 28-day supply from your previous surgery before registering*

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Do you purchase any regular supplements or medications over the counter or from any other source other than the GP surgery? If yes, please supply information

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**We now offer EPS(electronic prescribing services) at the practice. Please nominate the pharmacy that you use for your medications and prescriptions will then be sent electronically.**

Name of Pharmacy:

**Allergies:**

Have you had an adverse reactions to any medication

**Yes**  **No**

If yes, please state what medication and what reaction you have to it  
(i.e. sickness, rash, anaphylaxis)

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**Family history**

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

Heart Disease

**Yes**  **No**

Stroke

**Yes**  **No**

Cancer

**Yes**  **No**

What type of cancer?

Diabetes

**Yes**  **No**

Type 1 or Type 2(if known)?

## Veteran

Have you ever served in the military?

Yes

No

If yes , please provide brief details

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## Disability status

Do you suffer from any of the following disabilities?

Mobility

Visual

Hearing

Other-please specify

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## Communication

Do you have any communication / information requirements related to sensory loss? If so, what are they and how would you like us to communicate with you?

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## Carers

Do you need /do you have anyone who looks after you or your daily needs, such as a Carer?

Yes

No

If Yes, would you like them to deal with your health affairs here?

Yes

No

*If yes, a member of the reception can help to arrange this*

Do you care for someone?

Yes

No

*To register as an unpaid carer or to register that you are cared for, please ask for a form at reception*

**Female only**

Date of last smear

Date

Result

When was your last mammogram?

Have you had a hysterectomy?

**Yes**

**No**

What type ?

What method of contraception do you use?

If you have a mirena coil or other IUD, please provide date of insertion

Do you take HRT?

**Yes**

**No**