GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

NEYLAND & JOHNSTON MEDICAL PRACTICE

NEW ADULT PATIENT REGISTRATION HEALTH QUESTIONNAIRE

For information on how we will use your data please click on this link Full privacy notice - Hywel Dda University Health Board or go to https://hduhb.nhs.wales/about-us/governance-arrangements/your-information-your-rights/privacy-notices/full-privacy-notice/

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:

Preferred Pronouns: e.g.: he/him, she/her, they/them		Title (Mr/Mrs/Miss etc.)	
Surname:	First Name(s):		
NHS number:	D.O.B.		
Marital Status:			
Address:			
	Postcode:		
Home Tel Number:	Mobile Tel Number:		
Email Address:			
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 FIT 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 ☐			

ETHNIC ORIGIN: I would describe my ethnic origin as (please tick)

WHITE		**ASIAN, ASIAN WELSH OR ASIAN BRITISH**		**Black, Black Welsh, Black British, Caribbean or African**		**Mixed or Multiple Ethnic or Other Ethnic Group**	
Welsh		Indian		Caribbean		White & Black Caribbean	
English		Pakistani		African		White & Black African	
Scottish		Bangladeshi		Any other Black, Black British or Caribbean background		White & Asian	
Northern Irish		Chinese				Any other mixed or multiple ethnic background	
British		Any other Asian Background-					
						Arab	
						Any other ethnic group	

LANGUAGE PREFERENCE (Please select one)	WELSH		ENGLISH		OTHER	
If other, please specify:						
WHICH GENDER DO YOU INDENTIFY WITH (Please tick)						
MALE		FEMALE		OTHER PREFERRED DESCRIPTION		PREFER NOT TO SAY	

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

Name of next of kin	
Contact number	Relationship to patient
Other emergency contacts	
Name	
Contact number	Relationship to patient

LIFESTYLE					
Height (cm)		Weight (kg)		BMI	
Do you smoke?	Yes ☐	No ☐		Ex Smoker ☐	
If yes please state number of cigarettes per day _____, or ounces of tobacco _____					
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:					
750ml Bottle of Wine	10 units	*175ml (standard) glass wine*	2 units	*25ml(single) shot of spirits*	1 Unit
70cl(standard) bottle of spirits	28 units	*Pint of 3.6% lager/beer/cider*	2 Units	*Pint of 5.2% lager/beer/cider*	3 Units
How many units of alcohol do you drink each week? _____ units					
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					

EXERCISE			
Inactive ☐	Gentle ☐	Moderate ☐	Active ☐
DIET – do you follow a special diet?			
Yes ☐ No ☐ If yes, please specify:			

Medical History: Do you suffer from any of the following (please indicate as appropriate): -

Note: The information you provide us with may help us provide you with necessary care as we await your medical records from your previous surgery.

Diabetes No ☐ Yes ☐. If yes, please specify - Diet control ☐ Tablets ☐ Insulin ☐
Asthma No ☐ Yes ☐
COPD (Chronic Obstructive Pulmonary Disease)? No ☐ Yes ☐
Heart Disease No ☐ Yes ☐
High Blood Pressure No ☐ Yes ☐
Epilepsy No ☐ Yes ☐
Stroke No ☐ Yes ☐ If yes please specify the date:
Thyroid Problems No ☐ Yes ☐ If yes please specify the following: Hyperthyroid ☐ Hypothyroid ☐
Cancer / Tumors No ☐ Yes ☐ If yes please specify:
Have you received a blood transfusion before 1996? No ☐ Yes ☐
Are you currently under the care of a specialist consultant or undergoing specialist treatment? No ☐ Yes ☐ If yes, please provide relevant details:
Allergies: *Have you ever experienced an adverse reaction? If yes, please specify medication and/or environmental (including food stuffs etc.), and what reaction you experienced e.g. sickness, rash, anaphylaxis.* No ☐ Yes ☐
Female Only: Date of last smear (aged between 25 – 60 years): _____Next due: _____ Result: _____ Have you had a Hysterectomy? No ☐ Yes ☐ Please specify date of procedure and type: _____ When was your last mammogram (Over 50): _____ What method of contraception do you use? _____ If you have a Mirena coil or other IUD, please provide date of insertion: _____

Veteran Status
Are you a HM Forces Military Veteran? No ☐ Yes ☐ If yes please provide brief details:

Disability Status (please tick all that apply) – Do you suffer from any of the following disabilities?							
Mobility	☐	Visual	☐	Hearing	☐	Other please specify	☐
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?							

Carers	
Do you need / do you have someone who looks after you or your daily needs, such as a carer?	No ☐ Yes ☐
If yes, would you like them to deal with your health affairs? *If yes, a member of the reception team can help to arrange this.*	No ☐ Yes ☐
Are you an unpaid carer? *To register as an unpaid carer please ask for a form at reception.*	No ☐ Yes ☐

Family History – *Is there any of the following in your family (father, mother, brother, sister, grandparents) before the age of 65? Please specify the family member.*	
Heart Disease	No ☐ Yes ☐
Stroke	No ☐ Yes ☐
Cancer	No ☐ Yes ☐ State what type of cancer:
Diabetes	No ☐ Yes ☐ Type 1 ☐ Type 2 ☐ If known.

IF YOU ARE IN RECEIPT OF REPEAT MEDICATION, WOULD YOU PLEASE GIVE YOUR PERMISSION TO ALLOW PRESCRIPTIONS TO BE SENT TO YOUR CHOSEN PHARMACY ELECTRONICALLY (EPS). No ☐ Yes ☐ NAME OF NOMINATED PHARMACY:

Medication: Please list all repeat medications and attach a recent 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***

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