NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

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

Surname: ………………………………………Forename(s): ……………………………………

NHS number (important):............................................................................

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

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

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

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

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

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

Emergency contact Name & Number……:…………………………………………………………

Names of other household members registered at Roseneath………………………………….

Have you been registered at Roseneath previously \* Yes / No

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 electronic methods of contact available for patients to contact the surgery for non urgent requests, for example, eConsult is now used to triage all appointment requests to enable us to prioritise based on medical need. The submission on an eConsult will request an email address and we may reply to your eConsult using that address. However, in general we would not usually correspond by email outside of this process. **By using eConsult, it is taken that you consent to us being able to use your email to reply**.

***Please turn over.***

**Smoking**

Do you smoke? *Yes* / *No*

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

*We strongly encourage all smokers to quit. A free NHS service is available. Please telephone Help Me Quit on 0800 085 2219, visit* [*www.helpmequit.wales*](http://www.helpmequit.wales) *or text HMQ to 80818*

**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 PROVIDE A COPY OF YOUR REPEAT OR UPDATE TABLE)**

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*

Is your allergy mild, moderate or severe? ……………………………………………………………

What type of reaction does your allergy cause i.e. anaphylaxis, rash, vomiting etc? …………...

………………………………………………………………………………………………….……….…

……………………………………………………………………………………………………………..

**Past Medical History**

Please give details of any treatments/medical conditions:

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

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

(Additional needs/requirements data set)

**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?

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

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