

LLANISHEN COURT SURGERY NEW PATIENT QUESTIONNAIRE.

Please answer the following questionnaire to help us record your medical history.

Surname.....Forename(s).....
 Address.....Date of Birth.....
Telephone Number.....
MobileNumber.....
 Post Code..... E-mail.....
 Marital Status..... Todays Date:.....

Are you able to communicate in English? YES/NO

If not, please state your preferred language.....

Are you an Asylum seeker or a refugee? YES/NO – if yes, please provide details

Are you housebound? YES/NO – if yes, please provide details.....

Do you consent to being contacted by the practice via SMS (text Message) with important clinical information (e.g. test results, appointment reminders) YES/NO

Name and address of your previous GP surgery:

Please provide a copy of your current repeat medication if available.

Medical History

Please state any major chronic medical conditions you have that requires regular review by your GP or for which you take regular medications:

Do you have any Allergies? YES / NO Please state

Do you require a new patient consultation (as part of registration)? YES / NO

Smoking:

Have you ever been a smoker? YES / NO

If you a current smoker, how much do you smoke?.....

If you are an ex-smoker, how much did you smoker and when did you stop?.....

If you smoke something other than cigarettes? YES / NO

IF Yes please state what and how much.....

Alcohol review:

Are you a regular alcohol drinker? YES/NO

If yes, how many units per week do you drink?

WINE

- Small glass (125ml) = 1.5 Units
- Standard glass (175ml) = 2 Units
- Large glass (250mls) = 3 Units

BEER/LARGER/CIDER

- Pint or lower strength beer (3.6%) = 2Units
- Pint of Higher strength Cider/Beer.Larger (5.2%) = 3 Units
- Standard strength 440ml can (5.5%) = 2.5 Units

SPIRITS (Including Gin,RumVodka,Whisky,Tequila)

- Single measure (35ml) = 1.4 Units

How often do you have a drink containing alcohol?

(PLEASE CIRCLE BELOW)

NEVER / RARELY/ OCCASIONALLY /MONTHLY /WEEKLY /DAILY

On average how many units of alcohol do you consume on a typical week (on average)?.....

Lifestyle review:

So that we can calculate your BMI, please could you provide us with your Weight and Hight.

Height-

Weight-

Do you exercise regularly? YES/NO (If yes how often?)

Carer Information:

Are you a **CARER**? YES/NO If YES who do you care for:

Name.....

Address.....

Telephone Number.....Mobile.....E-mail.....

Relationship.....

Are they a Patient here? YES/NO

Are you assisted by a **CARER**? YES/NO If YES by whom.

Name.....

Address.....

Advanced Care Planning:

This section allows you to tell us of any specific wishes if you were to become seriously unwell.

Next of Kin details:

Name:.....

Telephone:

In case of an emergency are you happy for the surgery to contact your Next of Kin? YES/NO

Have you given anyone power of attorney for your health and wellbeing? YES/ NO

(if yes please provide details below and bring a copy of the document into the surgery for your medical records)

NAME	TELEPHONE
•	•
•	•
•	•

Do you have a Living Will? YES/NO

(If yes please provide us with details below & bring a copy of the document into to the surgery for your medical records)

Do you consent to this information being added to your medical records? YES / NO

Telephone Number.....Mobile.....E-mail.....

Relationship.....

Are they a Patient here? YES/NO

What is your ethnic group?

Please tell us which of the groups listed below best describes you. Choose one section from A to E, then tick the appropriate box to indicate your ethnic group. This is not compulsory and answers will be treated confidentially. If you prefer not to answer, tick the “not stated” box at the bottom.

Your Name:
Your Date of Birth:

		<i>Please tick one box only</i>	√
A: White	Welsh, English, Scottish, Northern Irish, British		<input type="checkbox"/>
	Irish		<input type="checkbox"/>
	Gypsy or Traveller		<input type="checkbox"/>
	Any other White background (please write in).....		<input type="checkbox"/>
B: Mixed / Multiple Ethnic Groups	White and Black Caribbean		<input type="checkbox"/>
	White and Black African		<input type="checkbox"/>
	White and Asian		<input type="checkbox"/>
	Any other Mixed background (please write in).....		<input type="checkbox"/>
C: Asian or Asian British	Indian		<input type="checkbox"/>
	Pakistani		<input type="checkbox"/>
	Bangladeshi		<input type="checkbox"/>
	Chinese		<input type="checkbox"/>
	Any other Asian background (please write in).....		<input type="checkbox"/>
D: Black or Black British	Caribbean		<input type="checkbox"/>
	African		<input type="checkbox"/>
	Any other Black background (please write in).....		<input type="checkbox"/>
E: Other Ethnic Groups	Arab		<input type="checkbox"/>
	Any other (please write in)		<input type="checkbox"/>
Not stated	I prefer not to answer		<input type="checkbox"/>