**New Patient Health Questionnaire for Patients Registered at**

**Harbourside Health Centre and St David’s Medical Centre**

Please complete any areas with \*

**Have you ever been registered with this practice before Yes 🞎 No 🞎**

**Your Contact Details\* Emis ID**

Title

Mr  Mrs  Miss  Ms  Other  Surname

Dr  Rev  Prof

Date of Birth       First Names

Preferred Name to be called

Occupation       Previous Surnames

Married  Co-habiting Single Divorced Widow Widower

Home Address including Post Code

Home Tel

Mobile

Work Tel

Email Address      

Consent to receive SMS texting Yes  No  emails Yes  No  in respect of information from the practice regarding appointments/results etc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information About You\***

Nursing Home\*

BP

What is your height?

What is your weight?

**What is your first language?**

**Do you need an interpreter? Yes**  **No**

**Ethnic Group\***

White British  Irish  Other  Please State:

Black Caribbean  African  Other  Please State:

Asian Indian  Pakistani  Chinese  Other  Please State:

Mixed White + Black  Caribbean White + Black African

White + Asian  Other  Please State:

**Asylum/Refugee Status\***

Have you made a **formal** **application** for Asylum to the **Home Office**? Yes 🞎 No 🞎

Have you been granted Refugee Status or someone who has arrived in the country through a Government initiative scheme e.g. The Refugee Gateway Scheme? Yes 🞎 No 🞎

**Medical Information\***

Please list any serious illnesses / operations / accidents / disabilities and for women any pregnancy related problems) and the year they took place:

**Have you ever suffered from? (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

**Are you registered disabled?\*** (If yes, please give details) Yes  No

**Have you ever served in the armed forces?\*** Yes  No  Which service?

**Are you allergic to any medicines/foods/substances and if so, which?\***

Yes  No

**Carers\***

**Do you have a carer?** (If yes please give contact details) Yes  No

**Are you a carer?** (If yes please give contact details) Yes  No

**Women\***

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

(Please state an approximate date)

Are you currently pregnant? Yes  No

If you are over 25 and under 65 years of age and due a cervical smear, please make an appointment with the nurse at your earliest convenience

If you wish to decline your smear please tick  and contact Cervical Screening Wales in writing to request to be removed from the National Register

You may change your mind at any time and make an appointment with the nurse for a smear

**Smoking (from 14 years of age)\***

**Do you smoke?** Yes  No  ***please tick***

**If 'No', have you ever smoked?** Yes  No  Date stopped smoking ­­­­\_\_\_\_\_\_\_\_\_\_

**If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per Day/week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cessation Advice**

**If you would like to speak to someone about giving up smoking, you can either make an appointment to speak to the Nurse, or we hold a smoking cessation advice service every Monday morning – no appointment needed. Is this something you would be interested in?** Yes  No *please tick*

**Children (Under 14 years of age)\***

**Does anyone in the household smoke?** Yes  No *please tick*

**Alcohol\***

How many units do you drink per week?



**Family History\***

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. **Please state your relationship to the individual** and in the case of cancer, the type of cancer.)

**Next of Kin\***

Please give **name, address and telephone number** of next of kin and state relationship **Mother**  **Father**  **Spouse**  **Friend**  **Other(**please state**)**

**For patients aged 65 and over or those with a chronic disease\* (e.g. asthma or diabetes)**

**Have you had a flu vaccination?** Enter date or 'never':

**Have you had a pneumococcal vaccination?** Enter date or 'never'

**Please list any medicines you take and the amount:\* *Please use separate sheet if needed***

**Benzodiazepine Policy: Please note that it is the practice policy that we do not prescribe regular benzodiazepine medication or sleeping tablets (examples include – Diazepam, Nitrazepam, Temazepam, Zopiclone and Zolpidem)**

**It is our practice policy for all new patients to be reviewed**

**All patients, without exception, who are taking the above medication will be started on a reduction program until the medication is stopped**

**This will be carried out in a controlled way following local health board guidelines**

**It is the patient’s responsibility to provide evidence of any current medication from their previous practice**

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE RETURN IT TO THE RECEPTIONIST, DOCTOR, OR NURSE. IT IS **IMPORTANT** THAT YOU MAKE AN APPOINTMENT FOR A NEW PATIENT MEDICAL TO ENSURE YOUR PLACE WITH THIS PRACTICE. PLEASE BRING A SPECIMEN OF YOUR URINE WHEN YOU ATTEND YOUR NEW PATIENT MEDICAL. THE RECEPTIONIST WILL SUPPLY YOU WITH A SPECIMEN BOTTLE.

**Please be advised: All medical records are held by this practice as computerised records only.** This ensures accuracy and consistency of data, and enables the doctors to have access to medical correspondence from the hospitals, clinics and other clinical bodies, including blood tests, as soon as they become available.

**All the information you have supplied is treated in a strictly confidential manner.**

SIGNED DATE

Please note: If you do not wish to have a disability recorded or special needs catered for please advise the nurse when you attend for your new patient medical. You will be asked to sign an indemnity to this effect.