**New Patient Registration over 5 years NPHC Booked for: ………………………**

**Your privacy your rights leaflet given? *Yes* / *No***

Please complete the registration form and the new patient health check form as fully as possible.

If you are on any repeat medication, please supply a list of medication with dosage, or a repeat prescription form from your previous GP.

You will need to show two forms of identification

|  |  |
| --- | --- |
| **Proof of identity seen Y / N** | **Proof of address seen Y / N** |
| Driving Licence Birth Certificate  Passport Student Card  Travel Card Medical Card  Other ……………………….. | Rent Card Utility Bill  Phone Bill Bank Statement Letter from benefits agency Council tax / water bill / home insurance policy |

We will also require your NHS number, if you do not have this, please contact your previous surgery and they will be able to supply this for you.

|  |
| --- |
|  |

**Patient Ethnic Origin Questionnaire**

**Name: …………………………………….. Date Of Birth: ………………………………………**

**First Language: ……………………….. Preferred Language: …………………………….**

This questionnaire follows the recommendations of the commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E and then tick **ONE** box to indicate your background.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A | White |  | British |  | B | Mixed |  | White and black Caribbean |
|  |  |  | Irish |  |  |  |  | White and black African |
|  |  |  | Other: |  |  |  |  | White and Asian |
|  |  |  |  |  |  |  |  | Other: |
|  |  |  |  |  |  |  |  |  |
| C | Asian |  | Indian |  | D | Black or |  | Caribbean |
|  | British |  | Pakistani |  |  |  |  | African |
|  |  |  | Bangladeshi |  |  |  |  | White and Asian |
|  |  |  | Other: |  |  |  |  | Other: |
|  |  |  |  |  |  |  |  |  |
| E | Chinese or other |  | Chinese |  |  |  |  |  |
|  | Ethnic Group |  | Other |  |  |  |  |  |

Dear Patient

As a newly registered patient of St. Thomas & West Cross, we would be grateful if you could complete this questionnaire. This will allow us to provide you with excellent medical care.

If you have any questions regarding this questionnaire or any other matter, please speak with a receptionist, they will be happy to answer your queries.

**ALL INFORMATION THAT YOU GIVE IS COMPLETELY CONFIDENTIAL**

**NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE**

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

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

NHS number (if known):......................................................................................

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

Address: …………………………………………………………………………………………………..

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

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

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

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

**Next of Kin:** Name: …………………………………….

Relationship: ……………………………………………. Contact Tel No: ………………………

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 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 (please delete as appropriate)**

Email address: …………………………………………………………………………………………

**Smoking**

Do you smoke? ***Yes* / *No***

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

If ex-smoker – when did you stop smoking? ……………………………..

Would you like to receive smoking cessation information? ***Yes* / *No***

**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 – www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units

Or you can use Alcohol Change’s calculator –

[www.alcoholchange.org.uk/alcohol-facts/interactive-tool/unit-calculator](http://www.alcoholchange.org.uk/alcohol-facts/interactive-tool/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: ……………………….**

**When was your blood pressure checked?** …………………………………

**Women Only: The date of your last smear?** ………………………………

***Please specify which language you prefer to be communicated in:*** ………………….

*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? …………………………………………………………………………………….

**Past Medical History**

**Have you ever suffered from the following illnesses?**

Diabetes *Yes*/*No If yes, date of diagnosis ……………*

High Blood Pressure *Yes*/*No If yes, date of diagnosis ……………*

Coronary Heart Disease *Yes*/*No If yes, date of diagnosis ……………*

Asthma *Yes*/*No If yes, date of diagnosis ……………*

Chronic Bronchitis *Yes*/*No If yes, date of diagnosis ……………*

Epilepsy *Yes*/*No If yes, date of diagnosis ……………*

Cancer *Yes*/*No If yes, date of diagnosis ……………*

Thyroid Disease *Yes*/*No If yes, date of diagnosis ……………*

Severe Mental Health Disorder *Yes*/*No If yes, date of diagnosis ……………*

Kidney Disease *Yes*/*No If yes, date of diagnosis ……………*

Atrial Fibrillation *Yes*/*No If yes, date of diagnosis ……………*

Please give details of any treatments/medical conditions:

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

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

Are you on medication and / or receiving any treatment at present for any medical condition?

**Yes/No**

**Blood Transfusion**

Have you ever had a blood transfusion? *Yes* / *No* Was this prior to 1996? *Yes* / *No*

**Medication**

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.

Repeat prescription can be ordered via email to: [prescriptions.w98016@wales.nhs.uk](mailto:prescriptions.w98016@wales.nhs.uk) or by attending the surgery.

**We no longer take prescription requests on the telephone.**

**PREFERRED PHARMACY NAME** …………………………………………………..

**Allergies**

Do you have any allergies? ***Yes*/*No***

If *Yes*, please give details:

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

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

**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)*

**If Yes, is the person you care for our patients Yes/No**

**Patient details (Name, DOB, Address etc)**

**……………………………………………………………………………………………………..**

**……………………………………………………………………………………………………..**

**Military Veteran**

Have you ever served in the Armed Forces?  **Yes/No**

*(Office use only – If Yes Please read-code 13q3)*

**Communication/Disability Access Needs**

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? **Yes/No**

*If yes, please specify what you require support with (e.g. hearing loss, visual impairment, speech/language difficulties)*

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

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

**Do you consider yourself to have a disability:**  **Yes/No**

Is there any other information relating to your disability that the Practice needs to be aware of? i.e. Wheelchair use, use of walking aid, need to attend with carer / helper etc.

If yes, please specify the nature of the disability

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

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

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