

New Patient Questionnaire



If you need help filling out this form, please ask our reception team who will be happy to help. Please ensure you complete this form and the purple form as fully as you can. Failure to do so may result in a delay to your registration and impact on the care we provide you. Once completed please hand **BOTH** forms into reception together, **Failure to do so may delay your registration.**

ALL INFORMATION PROVIDED IS CONFIDENTIAL

Date _____ NHS Number(if known) _____

Surname _____ Forenames _____

Address _____

Post Code _____ Telephone Numbers

Mobile _____ Landline _____ Work _____

E-mail address _____

Do you consent to receive correspondence from the practice by text message YES NO
Do you consent to receive correspondence from the practice by e-mail YES NO

Date of Birth _____ Ethnic origin _____

Occupation _____ Spoken Language _____

Do you require an interpreter Yes / No

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING ILLNESSES?

DIABETES YES NO HEART DISEASE YES NO

HIGH BLOOD PRESSURE YES NO EPILEPSY YES NO

ASTHMA YES NO

ANY OTHER MEDICAL CONDITION REQUIRING TREATMENT YES / NO

Further details if yes _____

Date of last cervical smear (women only) _____

Have you had a hysterectomy (women only) YES NO Date of procedure _____

Which of the following immunisations (vaccines) did you have as a child ?

Diphtheria Mumps Whooping Cough Tetanus Measles TB(BCG)

Polio German Measles Pneumonia

Others _____

Do you smoke? YES / NO If ex-smoker date quit _____

If yes. What do you smoke and how many a day Cigarettes Tobacco Cigars VAPE Pipe

Do you drink Alcohol? YES NO

How many units a week _____

e.g. 1 unit is a small glass of wine, a single spirit of ½ pint of beer

Have you ever used any other drugs? YES NO

ARE YOU ON ANY TREATMENT AT PRESENT?

If yes, please request a copy of repeat medication request slip form you previous Practice or Pharmacy you use.

Have any of you immediate family (parents, grandparents, brother, sisters) ever had a serious illness
e.g

Diabetes – Heart Attack – Angina - High Blood Pressure – Strokes – Epilepsy ? YES NO

Please Specify _____

CARER

Do you look after someone? YES NO
Does someone look after you ? YES NO

Contact details of Carer. Name _____

Telephone Number _____ Relative / professional agency / social care

ARE YOU A VETERAN ? YES NO

What service were you attached to _____

Have you any disabilities or additional needs the surgery should be aware of ?

Details : _____

Do you have a learning Disability? Yes NO

If known please provide us with your :

Weight _____ kg Height _____ cm Blood pressure _____ / _____

Cofrestru fel Rhoddwr Organau gyda'r GIG

NHS Organ Donor registration

Rwyf am gofrestru fy manylion ar Gofrestr Rhol Organau'r GIG fel rhywun y gellir trawsblannu ei organau/meinwe ar ôl fy marwolaeth. Ticiwch y blychau perthnasol.

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

Unrhyw un o'm horganau a'm meinwe neu
Any of my organs and tissue or

Arennau
Kidneys

Calon
Heart

Afu/lau
Liver

Cornbiliennau
Corneas

Ysgyfaint
Lungs

Pancreas
Pancreas

Unrhyw ran o'm corff
Any part of my body

Llofnod yn cadarnhau fy mod yn cytuno i roi organau/meinwe
Signature confirming my agreement to organ/tissue donation

Dyddiad _____ / _____ / _____
Date

I gael rhagor o wybodaeth, gofynnwch wrth y dderbynfa am daflen wybodaeth neu ewch i'r wefan www.uktransplant.org.uk
neu ffoniwch 0300 123 23 23

For more information, please ask at the reception for an information leaflet or visit the website
www.uktransplant.org.uk or call 0300 123 23 23.

Cofrestru fel Rhoddwr Gwaed gyda'r GIG

NHS Blood Donor registration

Hoffwn ymuno â Chofrestr Rhol Gwaed y GIG fel rhywun y gellir cysylltu ag ef a byddwn yn barod i roi gwaed.

Ticiwch yma os ydych wedi rhoi gwaed yn y 3 blynedd diwethaf

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.
Tick here if you have given blood in the last 3 years

Llofnod yn cadarnhau fy nghaniatâd i gael fy nghynnwys ar Gofrestr Rhol Gwaed y GIG
Signature confirming consent to inclusion on the NHS Blood Donor Register

Dyddiad _____ / _____ / _____
Date

I gael rhagor o wybodaeth, gofynnwch am y daflen ar ymuno â Chofrestr Rhol Gwaed y GIG.

Y cyfeiriad gorau i anfon gwylbodaeth iddo yw: (dim ond os yw'n wahanol i'r uchod, ee eich gweithle)

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is: (only if different from above, e.g. your place of work)

Cod Post Postcode:

I'w gwblhau gan y meddyg

To be completed by the doctor

Enw'r Meddyg
Doctors Name

Cod HB
HB Code

Rwyf wedi derbyn y claf hwn ar gyfer gwasanaethau meddygol cyffredinol
I have accepted this patient for general medical services

Rwyf wedi derbyn y claf hwn ar gyfer gwasanaethau meddygol cyffredinol ar ran y meddyg isod sy'n aelod o'r feddygfa hon
I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Enw'r Meddyg, os yw'n wahanol i'r uchod
Doctors Name, if different from above

Cod HB
HB Code

Byddaf yn gweinyddu meddyginaethau/teclynnau meddygol i'r claf hwn yn armodol ar Gymeradwyaeth yr Awdurdod lechyd
I will dispense medicines/appliances to this patient subject to Health Board Approval

Rwyf yn datgan bod yr wybodaeth hon, hyd y gwn i, yn gywir.
I declare to the best of my belief this information is correct.

Llofnod Awdurdodedig
Authorised Signature

Enw
Name

Dyddiad _____ / _____ / _____
Date

Stamp y Feddygfa
Practice Stamp