**NEW PATIENT REGISTRATION / HEALTH QUESTIONNAIRE**

Welcome to Tylorstown Group Practice.

**We require you to complete this questionnaire so that we can begin to process your new patient registration.**

Your medical records regarding your previous health are still with your last doctor and can take up to six months to arrive. It is therefore very important that you supply us with the appropriate information regarding your past and present health.

Please fill in ALL sections of the questionnaire giving as much information as you can.

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

We need your NHS Number to register you.

An NHS number is a 10-digit number, like 444 444 4444.

You can find your NHS number in any documents or letters sent to you by the NHS, such as:

* Prescriptions / Reorder form
* Hospital appointment letters
* Contacting your present GP

**Failure to provide your NHS number may result in a delay in your registration and the ability of this practice to obtain your medical records from your present GP.**

**Thank you for your time and cooperation**

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

NHS number: ..................................................Marital status: ………………………………....

Date of Birth: …………………………………. Place of Birth ……………………………………

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

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

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

Is this mobile number your own? Yes/No (*please delete as appropriate)*

*(If not your own what is the relationship to the patient):* ………………………………………….

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

Gender…………………………………… Occupation …………………………………………….

Ethnicity…………………….

Language preference English, Welsh or *Other (Please state) …………………………….…*

Next of Kin Contact details …………………………………………………………………………...

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?

**(please tick as appropriate)**

**Yes 󠇯 󠇯󠇙 (**admin use read code #9NdP**)**

**No 󠇯󠇙 (**admin use read code #9NdQ)

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?

**(please tick as appropriate)**

**Yes 󠇯󠇙 (**admin use read code #9NdS)

**No 󠇯󠇙 (**admin use read code #9Ndy)

**Do you have any relatives that are currently registered at Tylorstown Group Practice? Yes / No**

**If yes, please state patients name and relationship to yourself ……………………………**

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

**Smoking**

Do you smoke? *Yes* / *No*

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

Other (Please state) ……………………………………………………………………………….

Would you like help to quit? Yes / No

You can also visit <https://www.helpmequit.wales/>

**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 - <https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator>

**How many units of alcohol do you drink a week? ………………………………**

Would you like help to reduce your alcohol consumption? Yes / No

You can also visit <https://111.wales.nhs.uk/encyclopaedia/a/article/alcoholmisuse>

**Height and Weight**

Please tell us your most recent measurements for the following (if known)

**Height: ……………………….**

**Weight: ……………………….**

**Do you take regular exercise?** (*please delete as appropriate)*

Not at all / Once a week / twice a week / More than three times a week

*Please note, we may contact you to offer you support or advice if appropriate based on your submission.*

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***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? …………………………………………………………………………………….

**Patients Past Medical History**

Have you had a blood transfusion prior to 1996? Yes/No – Please circle.

Please tick if you have/had any of the following medical conditions:

Diabetes 󠇯󠇙

Stroke 󠇯󠇙

Heart Failure 󠇯󠇙

Ischaemic Heart Disease 󠇯󠇙

Atrial Fibrillation 󠇯󠇙

Hypertension 󠇯󠇙

Asthma 󠇯󠇙

Chronic Obstructive Pulmonary Disease (COPD) 󠇯󠇙

 **󠇙**

**Medication**

**Please attach or provide us your most recent repeat medication slip**

***We will not be able to process any prescriptions without it.***

**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*

*(Please provide written consent to a staff member that can ensure this is coded in your notes)*

Do you care for anyone else? *Yes*/*No*

*If yes, For whom? …………………………………………………………………………….....*

**Military Veteran**

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

Do you have a family member who served in the Armed Forces? Yes/No

If Yes, who? …………………………………………………………………………………

**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?

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

**FEMALES ONLY**

**Date of your last cervical smear test ……………………………………………………………**

**Are you taking any oral contraception? …………………………………………………………**

**Do you have a coil or Implant? If yes, please state which one? …………………………….**

**No of children? …………………… Have you had any miscarriages? …………………….**

**Have you had a hysterectomy? If so, what date? …………………………………………….**

**General**

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

***Thank you for completing this questionnaire. Your doctor will assess the information
provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.***

**My Health Text Message consent form**

Dear Patient,

Tylorstown Group Practice would like to offer patients the ability to receive text message reminders for your appointments booked at the surgery. We also hope to introduce sending other health information by SMS text soon. For example: we may ask you to contact us to make an appointment because your test results are back, let you know your test results are clear, invite you to a specialist clinic which we think you would be interested in, or invite you for seasonal vaccinations etc.

Messages are generated by a secure NHS Wales service; however, they are transmitted over a public network to your personal mobile phone, therefore they may not always be secure. We would like to assure you that the practice will not transmit any information that would enable someone to identify you, or which specify the test you may have had.

If you wish to receive this service, please complete your details in the section below and return it to the surgery at your earliest convenience.

|  |  |
| --- | --- |
| Patient name: |  |
| Date of birth: |  |
| First line of address: |  |
| Current mobile number: |  |
| • I consent to the practice contacting me by SMS text message for the purpose of providing health information and appointment reminders.• I will ensure that I keep the practice informed of any changes to my mobile number.• I acknowledge that SMS text message service is an additional service and that messages may not be sent on every occasion.• I understand that the SMS text message service should not be solely relied upon, as the responsibility of attending and cancelling appointments still rests with myself.• I acknowledge that I have the right to inform the practice if I no longer wish to receive communication from the practice via SMA text message. |
| Patient signature: |  |
| Date: |  |
| Office Use:  | Mobile Recorded |  | Consent Recorded |  | Scanned to notes |  |