

## New Patient Questionnaire

Please complete the following information and attached forms. It is important that we have ALL your current details to process your registration. Please be assured that all information is confidential.

### Personal Details:

Your full name: .....

Previous name: .....

NHS Number:.....

DOB: .....

Gender:.....

Current address: .....

.....

Previous address: .....

.....

Home Tel No: ..... Mobile 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)

Email address: .....

Do you consent to the practice contacting you by email?

\*Yes/No (please delete as appropriate)

Name & address of current GP: .....

.....

Next of kin Name : .....Relation:.....

Emergency contact telephone number: .....

Height:..... Weight:.....  
BMI:.....

**Please note the following information you supply may assist us to provide good care for you whilst we await your previous medical records.**

**Medical history:**

Please list all serious illnesses, medical conditions, past operations or any disabilities:

.....  
.....  
.....

Are you pregnant YES/NO .....

**Have you suffered from: (Brief details)**

Heart attack: YES/NO .....

Stroke YES/NO .....

High blood pressure YES/NO .....

Diabetes YES/NO .....

Asthma YES/NO .....

COPD YES/NO .....

Epilepsy YES/NO .....

Hypothyroidism YES/NO .....

Mental health illness YES/NO .....

Depression YES/NO .....

**Family history:**

Is there any family history of the following (if YES please give details ie relationship)

Heart disease: YES/NO .....

Asthma: YES/NO .....

Diabetes: YES/NO .....

Stroke: YES/NO .....

Cancer: YES/NO .....

Stomach problems: YES/NO .....

**Allergies**

Do you have any allergies? Yes/No

If Yes, please give details:.....

.....

**Medication:**

Do you take any regular medication: YES/NO

If YES we require a copy of a recent prescription. If you are unable to provide this, we will require a print out from your GP. Medication will not be prescribed without this.

Please give details of any medication which you take (prescribed or otherwise):

Name of Drug	Dosage

**Electronic prescribing service (EPS)**

Would you like your prescriptions sent to your nominated pharmacy using EPS? Yes/ No

Choose your nominated pharmacy for EPS : Llay, Gresford or Rossett

Have you ever been registered in England? Yes / No

Do you have an historic EPS pharmacy nomination? Yes/ No

If we discover an historic nomination, do we have permission to remove it? Yes/ No

**Smoking status:**

Do you currently smoke: YES/NO..... How many per day.....

If NO have you ever smoked: YES/NO.....

**Do you drink 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

Do you drink alcohol: YES/NO .....

If yes how many units per week:.....

**Do you exercise regularly? Yes / No**

If yes what sort of exercise and how often?.....

.....

**Are you a Veteran of the Armed Forces? YES/NO**

A 'Veteran' is defined as anyone who has served in HM British Armed Forces in the Army, Royal Navy, or Royal Air Force for at least one day, either as a Regular serving member or as a Reservist.

**Are you a carer? YES/NO**

If YES who do you care for:.....

**Do you have a disability, impairment or sensory loss which requires additional support with information and communication?** If yes please advise your preferred method of contact (such as telephone, text email etc) and if you require an interpreter at face-to-face appointments.

.....  
.....  
.....

Signature .....

(Patient/Parent/Guardian)

Date form completed .....

Thank you for completing the questionnaire.