# NHS Wales New Patient Registration/Health Questionnaire

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|---|---|---|---|---|
| Name: | | | Date of Birth: | |
| Address: | | | Post Code | |
| Tel No.: | | Mobile No.: (if over 16 years) | | |
| Marital Status | | Ethnicity: | | |
| NHS Number (if known) | | | Gender | |
| Occupation | | | | |

Language preference English / Welsh ***(please delete as appropriate)***

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: ……

| | | | |
|---|---|---|---|
| Height (Most recent) | | Weight (Most recent) | |
| Would you like information about having a healthy weight? | | | YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| Do you Smoke? | Never Smoked ☐ | Ex Smoker ☐ | Date Stopped: |
| | Smoker ☐ | Amount per week? | |
| If you are a smoker, would you like the details of Stop Smoking Wales? | | | YES ☐ NO ☐ |

| | |
|---|---|
| Do you drink alcohol? | YES ☐ NO ☐ |
| If Yes how many drinks PER WEEK<br>Please state: 3 pints, 1 bottle of wine, 3 Gins etc | |
| Would you like information about calculating your alcohol intake? | YES ☐ NO ☐ |

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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? …….

**Medication**

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

……
……
……

Please attach or forward us your most recent repeat medication slip, if you have one.

**Allergies**

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

If *Yes*, please give details: ……

**Past Medical History**

Please give details of any treatments/medical conditions:

……
……

**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)*

**Military Veteran**

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

**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?

……
……
……

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