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**Patient Registration**

**Please make sure you have provided your NHS number on the purple registration document.**

***Please provide either one form of identification from Box A or 2 from Box B***

**Box A**

|  |  |  |
| --- | --- | --- |
| **Form of identification (please tick)**  √ **Passport, license or cert number** | | |
| **Birth Certificate** |  |  |
| **Valid UK Passport** |  |  |
| **Valid non – UK Passport** |  |  |
| **Valid UK photo driving license** |  |  |
| **Birth Certificate** |  |  |

**Box B**

|  |
| --- |
| **Other form of identification and/or confirmation of address**  (Rental agreement, utility bill, Bank statement, mobile phone contract, DHSS letter, electoral role etc) |
|  |
|  |

**Have you previously been registered at this Practice Yes/No**

**Ethnicity: ............................................................................................................................**

**Gender: ..............................................................................................................................**

**Language preference English/Welsh/other**

* **Where available do you consent to the Practice contacting you by text messages 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 (**[**Enquiries.W00067@wales.nhs.uk**](mailto:Enquiries.W00067@wales.nhs.uk)**) 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?**

**New Patient Health Questionnaire**

***NB: The following information you supply may assist us to provide good care for you whilst we wait for your previous medical records.***

**Height and Weight**

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

**Height: ………………………..**

**Weight: ……………………….**

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

**Smoking**

Do you smoke? *Yes* / *No*

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

**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 - Alcohol units - NHS (www.nhs.uk)

Or you can use Alcohol Change’s calculator - [Unit calculator | Alcohol Change UK](https://alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator)

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

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**Family History**

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65 who have suffered with any of the following?

Heart Disease? *Yes* / *No* which family member? ………………………….

Stroke? *Yes* / *No* which family member? ………………………….

Cancer? *Yes* / *No* which family member? ………………………….

**Significant Medical History**

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We request that you contact your previous surgery and obtain a summary of medication which should be sent to Argyle Medical Group on [enquiries.w00067@wales.nhs.uk](mailto:enquiries.w00067@wales.nhs.uk) at your earliest convenience to avoid delay in obtaining supplies of medication. Repeat slips are not usually acceptable as proof but may be handed in for notes. It would also be helpful to provide the contact details of your surgery so that we are able to contact them if needed.

**Allergies**

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

If *yes*, please give details:

Drug

………………………………………….........................................................................................

………………………………………….........................................................................................

Non drug.

…………………………………………..........................................................................................

…………………………………………...........................................................................................

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**Carers and Next of Kin**

Please give details of your Next of Kin and/or anyone who may be assigned as your lasting Power of Attorney………………………………………………………….

Do you need/have anyone who looks after you or your daily needs as an unpaid Carer? *Yes*/*No*

*\*Our Carers champion Mrs Jo Bidgood will help with any queries you may have regarding your carers role and how we can help in the GP setting she will also forward your details to any relevant groups or outside agencies which are appropriate to you.*

**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.***

Reception Initials: