## **CADWGAN SURGERY**

## **NEW PATIENT QUESTIONNAIRE**

This questionnaire has been designed to help us get to know you and your medical history. The information you provide will be treated confidentially.

<u>Please bring a sample of urine with you to your health check together with proof of your</u> <u>identity eq passport/driver's licence and proof of your address eq utility bill/bank statement.</u>

Today's date: DD/MM/YY

Personal de	Household Details				
MR/MRS/MISS/MS/OTHER		Who lives at home with you? (Please list.)			
NAME		Name(s)	Date of birth	Relationship	School/job
PREVIOUS NAME(S)					
MARITAL STATUS					
DATE OF BIRTH					
ADDRESS					
HOME TELEPHONE NUMBER					
MOBILE NUMBER					
Consent for Text message reminder YES/NO					
OCCUPATION					
Retired/Full-time/Part-time/Unemployed		_		ldren	
Do you have a disability that we need to be made aware of		Do you have any children not already listed above? Please list their name(s)			
when contacting or visiting the surgery?					
If so, please state					
WHICH ETHNIC GROUP DO YOU BELONG TO? (Please tick		Date of birth			
one)					
White	Chinese	Address			
Black/Black British	Mixed	7001633			
Asian or Asian British		School/job			

	DISABILI	ТҮ	ALLERGIES
	YES/NO	DETAILS	Are you allergic to any tablets or medicines? Yes/no
Do you have a disability or long term condition? Do you have a carer?			If yes then please list details. Are you allergic to anything else? Yes/no
Are you a carer?			If yes then please give details.

	PAST MEDICAL HISTORY	
Do you have any of the Follow	ng? (please circle) :-	
Heart Disease - yes/no		
Stroke – yes/no		
Diabetes – yes/no	Are you under the retinal screening programme? - yes/no	
High blood pressure – yes/no		
Asthma – yes/no		
Epilepsy – yes/no		
Mental illness – yes/no		
HIV – yes/no		
Thyroid problem – yes/no		
Other – please give details		
Have you had any operations?	Please give details.	
Have you ever served in HM	Armed Forces? Y N	
FOR OFFICE USE ONLY	Read Code – 13q3	
	Passed to admin to request records date	
	Immunisations	

	Tetanus	Polio	Hepatitis A	Hepatitis B	Typhoid	Flu vaccine	Pneumococcus vaccine	MMR/Rubella	HPV
Yes/no									
Date									

Family History				
Does anyone in your close family have/has anyone had:-				
	Yes/no	Brief details	Age at first diagnosis	
Heart disease				
Stroke				
High blood				
pressure				
Diabetes				
Glaucoma				
Breast cancer				
Ovarian cancer				
Bowel cancer				
Other				

Women Only
When was your last cervical smear?
Have you had a hysterectomy? If so, date?
What is your method of contraception if used?
Please list details of your pregnancies including any miscarriages/Terminations of pregnancy

Men Only
Do you have any urinary problems? Yes/no
Do you examine your testicles? Yes/no
( regular self-examination of the testicles is recommended)
Do you have any Erectile problems? Yes/no
NB Your GP/practice nurses are available to discuss any problems and treatments may be available.

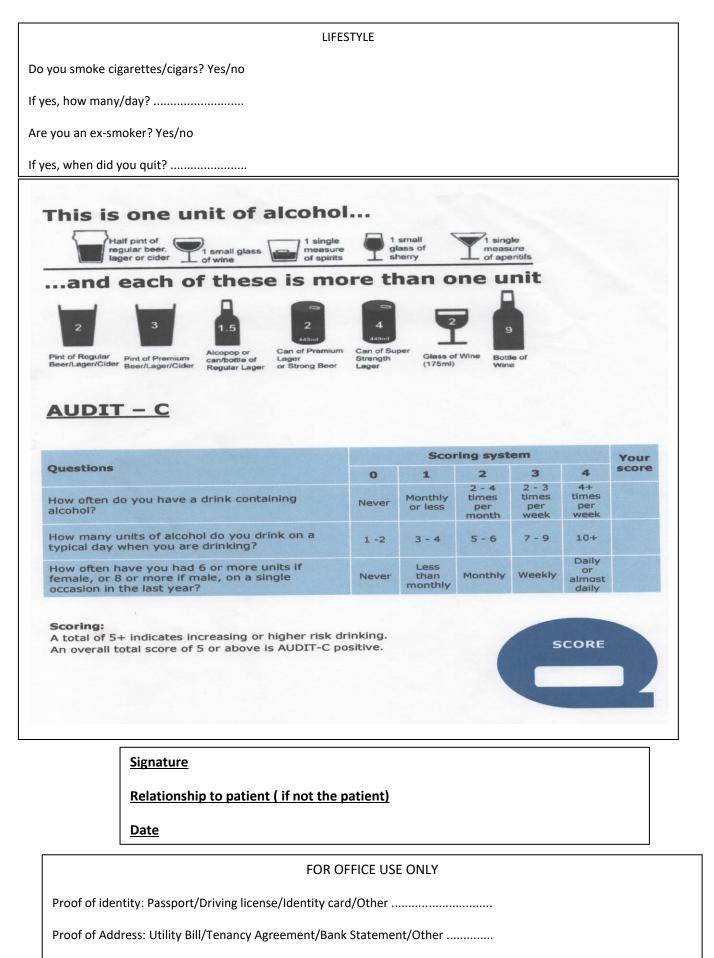
I would like to register for the online repeat ordering service? - My Health Online (MHOL) YES/NO

Registration form and PIN printed and given to patient YES/NO

## MEDICATION

Please list your regular medications below and bring your repeat prescription request slip from your previous GP with you when you attend for your health check.

Name of medication	Strength	Dosage



If aged under 16 years child was accompanied today by .....

Relationship to child .....

Height ..... Weight ..... BP .....

Urine dipstick test result .....

If AUDIT-C score = 5 or more, Full AUDIT screen score=.....