Cathays Surgery - New Patient Health Forms (ADULT)

Please complete as accurately as you can and return to the practice

Identification & Contact Details

Forename (s):		Date of birth:	(dd/mm/yyyy)
Surname:		Gender:	
Town/Country of birth:		**Will you require a translator support?**	**Yes / No** (We can only provide translation support **DURING** appointments)
Main lanugage spoken:			
Home phone number:		Mobile phone number:	
Email address:		Preferred method of contact:	Phone / SMS / Email

Are you happy for us to send you health-related marketing text messages or emails? We may occasionally wish to send you invitations to clinics and other health care services that we feel would be beneficial to you and your health, such as flu vaccines. This is now being classed as marketing. **Be assured, we will NEVER share your details to a non-NHS third-party organisation for marketing purposes.**	Yes / No

Emergency Contact Name:			
Their relationship to you:		**Their phone number:**	

Do you have any children? If yes, please provide their details. If they are registered or registering at Cathays Surgery too, please let us know so we can link them to your records.	Name	Boy / Girl	Age	Also registered here? Yes / No Yes / No Yes / No

Lifestyle Questions

Occupation:			
Are you a student?	Yes / No	If yes, what are you studying and when does your course end?	Course Subject: _____ End Date: _____ Month & Year
Are you an asylum seeker/refugee?	**Yes / No**	Are you a veteran?	Yes / No
What is your marital status?	Single / married / divorced / widowed	Who do you live with?	Alone / family or flatmates / homeless

Health Screening Questions

Height		Weight	
Do you exercise regularly?	Yes / No _____ times a week cardio / strength / yoga / other _____		
Have you had cervical screening/ smear test?	Yes / No	Women ages 25 and over should have a smear test every 3 years. If you have not had one recently, please contact us to book an appointment.	
Do you smoke?	Yes / Have never / Used to _____ cigarettes a day When did you start? _____ When did you stop?_____		

Our local pharmacy Woodville Pharmacy provides a FREE smoking cessation service. If you are looking to quit smoking, please contact them on **02920 227835**.
You can also call HELP ME QUIT on **0800 0852219** or visit **www.helpmequit.wales**

Do you drink alcohol?	Yes / Have never / Used to _____ units a week When did you start? _____ When did you stop?_____

If you drink more than 14 units (women) or 21 units (men), you may want to consider reducing your intake.
Contact us if you would like to discuss this with one of our clinicians.
Further information and support can be found our website page **'Unhealthy Habits'**

Have you ever missused drugs or taken drugs recreationally? This could include recreational drug use, addiction, legal and/or illegal drugs	Yes / Have never / Used to What drug(s)? _____ When did you start? _____ When did you stop?_____

If you would like to discuss drug misuse or recreational drug use with one of the clinicians, please contact us.
Further information and support can be found our website page **'Unhealthy Habits'**

Turn the page to continue...

Medical History

Do you have any allergies that you are aware of?	Yes / No - If yes, please give details below.		
	Allergy to - e.g. foods, drugs, animals etc.	**Type of reaction e.g. rash, swelling etc.**	**Severity**

Have you EVER suffered from the following? - if yes, please tick the appropriate box and add the date you suffered from the condition.			
☐ - Heart Attack	☐ - Epilepsy	☐ - Diabetes	☐ - Depression
☐ - Angina	☐ - Thyroid Disorder	☐ - Emphysema / COPD	☐ - Anxiety
☐ - Stroke	☐ - Cancer	☐ - Dementia	☐ - Other Mental Health
☐ - High Blood Pressure	☐ - Asthma	☐ - Tuberculosis (TB)	☐ - Jaundice
☐ - Skin Disease	☐ - Stomach Ulcers	☐ - Kidney Disease	☐ - Hayfever
☐ - Malaria	Please give details of any other significant illnesses or operations you have had here:		

Do you have a family history of any illnesses? If yes, please give details.	

Have you ever been tested for the following?			
Hepatitis B	Yes / No	Positive / Negative	Date:
Hepatitis C	Yes / No	Positive / Negative	Date:
HIV	Yes / No	Positive / Negative	Date:

Do you have any disabilities? - if yes, please tick the appropriate box and add the date you suffered from the condition.			
☐ - Impaired Hearing/Deaf	☐ - Speech Impaired	☐ - Partially Sighted/Blind	☐ - Mobility Impaired
☐ - Learning Disabilities	☐ - Other, please give details here:		

Support

Do you require any specific support? - if yes, please give details of what support you require.	Yes / No	If yes, give details:	
Do you have a carer? If yes, please provide their details.	Yes / No	Your carer's name:	
		Your carer's phone number:	
Are you a carer for someone else?	Yes / No	Who do you care for?:	
		Are they registered as a patient here?:	

Immunisations

Have you had the following immunisations/vaccines?	
☐ - ACWY Meningitis Date: _____	☐ - MMR Booster (Measles, Mumps, Rubella) Date: _____
☐ - BCG/HEAF test Date: _____ Do you have a BCG scar? Yes / No	☐ - Covid-19 Date of 1st dose: _____ Date of 2nd dose: _____

Thank you for completing this form!