HIRWAUN MEDICAL CENTRE

High Street, Hirwaun, Aberdare, CF44 9SL

Date Form Completed:	

To be fully registered with this practice, this form MUST be completed fully

NEW PATIENT HEALTH QUESTIONNAIRE

TITLE:		**FIRST NAME:**	
SURNAME:			
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
MARITAL STATUS:			
ADDRESS (incl flat no):		**Have you ever served in HM forces?** **Enlisted Date:** **Discharge Date:** **Service Number:**	**YES** ☐ **NO** ☐ (please tick)
		ARE YOU A CARER FOR SOMEONE? **If yes, please specify:**	**YES** ☐ **NO** ☐ (please tick)
HOME TEL:		**WORK TEL:**	**MOBILE TEL:**
EMAIL ADDRESS:			
Emergency Contact (Name, Address, Tel No.)			
ARE YOU HAPPY TO HAVE MESSAGES LEFT ON THE FOLLOWING NUMBERS?	**HOME TEL:**	**YES** ☐ **NO** ☐ (please tick)	
	MOBILE TEL	**YES** ☐ **NO** ☐ (please tick)	
Do you consent to allow the Practice to text you non-clinical information and reminders to your mobile number:		**YES** ☐ **NO** ☐ **(please tick)**	
OCCUPATION:			
ARE YOU CURRENTLY A STUDENT?	**YES** ☐ **NO** ☐	**IF YES, WHERE?**	

Do you have a sensory or communication disability?

Hearing / Sight

(Please detail below, for example if you require large text or an interpreter)

……..

WOMEN ONLY					
Date of Last Smear?		**What was the Result?**		**Where was it taken?**	
No. of Pregnancies?		**No. of Children?**		**Are you pregnant now?**	

GENERAL					
Height?		**Weight?**		**BMI?**	

SMOKING HABIT				
Are you a current smoker?	**If Yes**		**If No**	
YES ☐ **NO** ☐ (please tick)	**No. Cigarettes per day?**		**Have you ever smoked?**	
	No. Cigars per day?		**If yes, what year did you stop?**	
	Tobacco per week? (grams)		**How many *did* you smoke per day?**	
	Would you like help to stop?	**YES** ☐ **NO** ☐		

ALCOHOL INTAKE	
Do you drink alcohol?	**YES** ☐ **NO** ☐ (please tick)
If Yes: Wines / Spirits: units per week	
Beer: units per week	
1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer	

MEDICATION

ARE YOU ON ANY REGULAR MEDICATION? **(including inhalers or the contraceptive pill)**	**YES** ☐ **NO** ☐ (please tick)

*******(Please note that you need to see a GP, if on existing medication, for a first repeat prescription to be issued. Make an appointment with a GP for a review of your medication in good time and before you run out!)*******

If yes, please state name and dose or attached repeat prescription from previous surgery:

ARE YOU ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state type and name:

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
If Asthmatic, have you used your inhaler in past 12 months?	**YES** ☐ **NO** ☐		
COPD (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐		
Any other illnesses			

FAMILY HISTORY

Has a first degree relative (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**	
Asthma	**YES** ☐ **NO** ☐	**Who?**	
COPD	**YES** ☐ **NO** ☐	**Who?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐

If Yes, Please give details:

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the practice

NAME _____ **DOB** _____

What is your main language?

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
Scottish	
English	
Welsh	
Northern Irish	
British	
Irish	
Gypsy/Traveller	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian Scottish, or Asian British	
Pakistani, Pakistani Scottish, or Pakistani British	
Indian, Indian Scottish or Indian British	
Bangladeshi, Bangladeshi Scottish, or Bangladeshi British	
Chinese, Chinese Scottish, or Chinese British	
Other Asian, please specify:	

D. African	
African, African Scottish, or African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean Scottish, or Caribbean British	
Black, Black Scottish, Black British	
Other Caribbean or Black, please specify:	

F. Other ethnic group	
Arab	
Other, please specify:	

If you would prefer not to provide this information, please tick here:	
If you don't know your ethnicity, please tick here:	