



**TENBY SURGERY**  
**NEW PATIENT QUESTIONNAIRE**



As part of our registration procedure you are required to have a consultation with the Health Care Assistant prior to seeing a Doctor, which will include a short medical examination.

**Please complete this questionnaire and return it to reception.**

**PERSONAL DETAILS**

Name: ..... Date of birth .....

Address: .....

.....

Post code: ..... **Email Address:**.....

**Tel No:** ..... **Mobile:**.....

Occupation: .....

Marital Status : ..... No. of Children .....

Do you speak Welsh? .....

**Emergency Contact Details;** These contact details will only be used in the event of an emergency

Next of Kin (Name & Tel Number).....

.....

Any other Emergency Contact Details;.....

.....

**LIFESTYLE**

Do you smoke **NEVER**  **EX-SMOKER**  **YES**  How many per day? .....

Do you drink alcohol **YES**  **NO**  How many units per week.....

Do you take exercise regularly? **YES**  **NO**

If YES how many times per week and what type of activity?

.....

Do you follow a special diet? **YES**  **NO**

If YES what type? .....

**MEDICAL HISTORY – PLEASE TICK AS APPROPRIATE**

<b><u>DIABETES</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES, are you on	DIET <input type="checkbox"/>	TABLETS <input type="checkbox"/>	INSULIN <input type="checkbox"/>
Date of onset (if known).....			
<b><u>ASTHMA</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES date of onset ..... Date of last attack .....			
<b><u>COAD</u></b> (Chronic Obstructive Airways Disease)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES date of onset (if known).....			
<b><u>HEART DISEASE</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES please specify details (if known) .....			
Date of onset (if known) .....			
<b><u>HIGH BLOOD PRESSURE</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES date of onset (if known).....			
<b><u>EPILEPSY</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES date of onset and last seizure date (if known)...../.....			
<b><u>STROKE</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES date of onset (if known).....			
<b><u>THYROID PROBLEMS</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
If YES please state details (if known ) .....			
<b><u>CANCER OR TUMOURS</u></b>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
Please specify type: .....			

**MEDICATION**

Please list all repeat medication or attach you repeat list from your previous Doctor to this form.

.....  
.....  
.....  
.....  
.....  
.....  
.....

**ALLERGIES**

Are you allergic to any medication?    YES                       NO  

If YES please state .....

**FAMILY HISTORY**

Please state any illnesses your family or blood relative have suffered from:

.....  
.....  
.....  
.....

**IMMUNISATIONS**

Please give the date of your last Tetanus .....

**MILITARY SERVICE**

Have you ever served in any branch of the military?            Yes                       No  

If yes please give brief details.....  
.....

**Tenby Surgery would like to provide support and guidance to anyone providing unpaid care for someone who, due to their age, health or disability, would be unable to manage alone.**

Do you CARE for someone?    YES                         NO                     

Does someone CARE for you?    YES                         NO                     

If you have answered YES to either of the above questions, please fill in an additional **CARERS FORM** which is available at reception.

ONCE YOU HAVE COMPLETED A FORM, A CARERS PACK WILL BE SENT TO YOU WHICH CONTAINS FURTHER INFORMATION ABOUT THE SERVICES AVAILABLE TO CARERS.

All Carers are entitled to a **CARERS ASSESSMENT**. This can provide you with a link to help and support.

**WOMEN ONLY**

Date of last smear?                      .....    Result if known                      .....

When was your last mammogram? .....

Have you had a hysterectomy?    YES                         NO                     

What method of contraception do you use? .....

Do you take HRT?                      YES                         NO                     

**OPERATIONS**

Please state any operations or surgery that you have under gone in the past

**ADDITIONAL INFORMATION**

Please state any additional information which you think may be helpful.

Signed .....                      Date .....

**ETHNIC ORIGIN QUESTIONNAIRE**

I would describe my ethnic origin as follows:-

**Asian or Asian British**

- Bangladeshi
- Indian
- Pakistani
- Any other Asian background

**Black or black British**

- African
- Caribbean
- Any other black background

**Mixed**

- White and Asian
- White and Black African
- White and Black Caribbean
- Any other mixed background

**White**

- British
- Irish
- Any other white background

**Other Ethnic Group**

Please state .....

- I do not wish to disclose my ethnic group