	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? ………………………………………………………………………………

<u>**Emergency Contact Details;**</u> 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

DIABETES YES □ NO □

If YES, are you on DIET □ TABLETS □ INSULIN □

Date of onset (if known)……………………………….

ASTHMA YES □ NO □

If YES date of onset …………………………. Date of last attack …………………………….

COAD (Chronic Obstructive Airways Disease) YES □ NO □

If YES date of onset (if known)………………………….

HEART DISEASE YES □ NO □

If YES please specify details (if known) ………………………………………………………….

Date of onset (if known) …………………………

HIGH BLOOD PRESSURE YES □ NO □

If YES date of onset (if known)…………………………

EPILEPSY YES □ NO □

If YES date of onset and last seizure date (if known)……………………/……..………………

STROKE YES □ NO □

If YES date of onset (if known)………………………….

THYROID PROBLEMS YES □ NO □

If YES please state details (if known) …………………………………………………..

CANCER OR TUMOURS YES □ NO □

Please specify type:

……

MEDICATION

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

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……

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……

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