ST. DAVID'S STREET SURGERY, TON PENTRE

NEW PATIENT QUESTIONNAIRE – COMPULSORY INFORMATION
PLEASE ANSWER AS MUCH AS YOU CAN, PUTTING N/A IF NOT APPLICABLE

PERSONAL DETAILS

Surname:	Forename(s):	Gender: Male / Female
D.O.B.	Previous Surname:	Race: Languages spoken:
Address and Postcode:		Home tel: Mob tel:
Previous Address and Postcode:		
Name and Address of Previous GP:		Date last saw GP:
Are you happy for any personal information to be shared with other official Departments who must keep the information confidential?		Yes / No
Occupation:	Height:	Weight:
Smoker: Yes / No If yes, how many per day?	Alcohol intake: How many units, pints or glasses per week?	Current state of health: Good / Fair / Poor

MEDICAL HISTORY

History of illness(es) / operations:	Hereditary illness(es):	Current medication(s):
Immunisations status:	Allergies:	Have you ever used illegal drugs? If so, please specify:

Is your diet health conscious? Yes / No	Do you exercise regularly? Yes / No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES:

Diabetes	☐	Hypertension	☐	TB	☐	Heart Disease	☐	Cervical Cancer	☐
Thyroid	☐	Asthma	☐	CVA	☐	Breast Cancer	☐	Any Other	☐

FAMILY HISTORY OF ANY ILLNESSES

Diabetes	☐	Hypertension	☐	TB	☐	Heart Disease	☐	Cervical Cancer	☐
Thyroid	☐	Asthma	☐	CVA	☐	Breast Cancer	☐	Any Other	☐

COMMUNICATION

Do you have any sensory loss issues? If yes, please specify:	Do you have any communication difficulties? If yes, please specify:	Do you require an interpreter for appointments?

TEXT MESSAGING

Are you happy for us to send you reminders by text message? If so, please provide the best mobile number:

DISABILITIES / DIFFICULTIES

Do you have any disabilities that we need to know about in order to help us ensure you have the best possible consultations and access to the Practice? (ie learning difficulties, wheelchair bound etc)

FEMALE PATIENTS ONLY

Have you had a hysterectomy?	Yes / No	Date of Last Smear:
Are you pregnant?	Yes / No	If yes, expected due date?

ALL PATIENTS

Are you a Carer? (other than for your own well child)	Yes / No	If yes, for who?
Are you disabled, blind or deaf?	Yes / No	If yes, details:

VETERANS

Have you ever served in the Armed Forces?	Yes / No	If yes, when did your service end?
Are you under any veteran health Services?	Yes / No	If yes, are you able to give details please:

NEXT OF KIN

Please provide details if you wish:

ADDITIONAL CONTACT DETAILS

If there are any family members that you are happy for us to contact to try and reach you, please provide details below:

ANYTHING ELSE WE NEED TO KNOW ABOUT

Please let us know if there is anything else we need to know in order to assist us in providing the best service to you: