Castle Gate Medical Practice

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

(NB all information supplied will be recorded in your confidential medical records)
Please complete ALL fields. This will avoid the need to contact you for additional information

Surname: …… Forename(s): ……...

NHS number (if known): ..... Date of Birth: ..... Marital status: .....

Address: …….

…….……Postcode: ...……....

Home Tel: …… Mobile (if aged 16 and over): ……..

Email address: ……..

Gender: ……..

Ethnicity (please circle):

Asian, Asian Welsh or Asian British	**Black, Black Welsh, Black British, Caribbean or African**	**Mixed or multiple ethnic groups**
• Indian • Pakistani • Bangladeshi • Chinese • Any other Asian background	• Caribbean • African • Any other Black, Black British, or Caribbean background	• White and Black Caribbean • White and Black African • White and Asian • Any other Mixed or multiple ethnic background
White	**Other ethnic group**	
• Welsh, English, Scottish, Northern Irish or British • Irish • Gypsy or Irish Traveller • Any other ethnic group	• Arab • Any other ethnic group	

Next of kin: ……Relationship to patient……...

Contact Number .....……

Next of kin: ……Relationship to patient……...

Contact Number .....……

Have you previously been registered at the practice: **Yes/No**

What is your preferred language: ……

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NHS Wales App
Via the app, patients can book and cancel appointments, request repeat prescriptions (24 hours a day), update personal information, and view your medical record summary. Download the app from your smartphone or tablets app store or use the desktop version here https://app.nhs.wales/login

Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, to let you know that your prescription or your sick note is ready for collection and anything else relevant to your healthcare?

Yes/No

We have an electronic method of contact available for patients to contact the surgery for non urgent requests – do you consent for us to correspond with you via this method and supply us with a preferred e-mail address for this purpose?

Yes/No

Smoking

I have never smoked tobacco: ☐

I am an ex-smoker: ☐ When did you stop: …….

I currently smoke: ☐

How many: Cigarettes per day ……. Ounces of tobacco per day ……

Alcohol
For the following questions please answer to the best of your knowledge: We have provided a basic guide to alcohol content below to assist your completion:

A 750ml bottle of wine contains 10 units
A standard (175ml) glass of wine contains 2 units
A single small shot of spirits (25ml) contains 1 unit
A standard 70cl bottle of spirits contains 28 units
A pint of 3.6% strength lager/beer/cider contains 2 units
A pint of 5.2% strength lager/beer/cider contains 3 units

Or you can use Alcohol Change's calculator - https://alcoholchange.org.uk/

How many units of alcohol do you drink a week? ……...

Height and Weight

Please provide your most recent measurements for the following (if known)

Height: ……..

Weight: ……

Please note, we may contact you to offer you support or advice if appropriate based on your submission.

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NB: The following information you supply may assist us to provide good care for you whilst we wait for your previous medical records.

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease? ***Yes / No*** which family member? …….

Stroke? ***Yes / No*** which family member? …….

Cancer? ***Yes / No*** which family member? …….

Site of cancer? …….

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug	**Dosage**

Please attach or forward us your most recent repeat medication slip if you have one.

Allergies

Do you have any allergies? ***Yes/No***

If *yes*, please give details:

……

……

Past Medical History

Please give details of any treatments/medical conditions:

……

……

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Carers

Are you a carer: ***Yes/No***
(If yes, you will be sent some carer information)

Do you have a carer who looks after you or your daily needs? ***Yes/No***

If *yes*, would you like them to deal with your health affairs here? ***Yes/No***

Military Veteran

Have you ever served in the Armed Forces? **Yes/No**

Communication
Do you have any communication/information needs relating to sensory loss and, if so, what are they and how would you like us to communicate with you?

……
……
……
……

Thank you for completing this questionnaire.