

**Hay-on-Wye and Talgarth Medical Practice**

**Patient Questionnaire**

FULL NAME ……………………………………………………………..……… TITLE …………….

ADDRESS …………………………………………………………………………………………….

…………………………………………………………………………………………….

……………………………………………… POSTCODE ……………………………

HOME TEL ………………………………….. WORK TEL ………………...………………….

(provide if you are happy to be contacted on this number)

MOBILE …………………………………..

E-MAIL …………………………………………………………………………………………….

Will you accept contact via mobile phone/text reminders? Yes / No

Will you accept contact via e-mail? Yes / No

DATE OF BIRTH ………………………... PREFERRED LANGUAGE………………………..

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What is your height? ……………….. What is your weight? ………………..

**SMOKING** Never smoked Yes / No

Ex-smoker Yes / No

Current smoker Yes / No

If you are a current smoker, would you be interested in support to stop smoking? Yes / No

**ALCOHOL INTAKE** On average, how many units do you drink per week? …...........

(Half a pint of beer = a glass of wine = one measure = one unit of alcohol)

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**CHRONIC DISEASE** Have you been diagnosed with any of the following :-

|  |  |  |
| --- | --- | --- |
| **Chronic Disease** | **Yes / No** | **Date of Onset/Diagnosis** |
| Angina |  |  |
| Asthma |  |  |
| Cancer |  |  |
| COPD (Chronic Obstructive Pulmonary Disease) |  |  |
| CHD (Coronary Heart Disease) |  |  |
| Diabetes |  |  |

Other Medical Conditions ……………………………………………………………………………….

**FAMILY HISTORY** If a member of your family suffers/has suffered from any of the following, please state at what age in the appropriate box per example :-

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **FATHER** | **MOTHER** | **BROTHER** | **SISTER** | **OTHER** |
| *Example* | *65* |  |  | *32* |  |
| Angina |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| COPD |  |  |  |  |  |
| CHD |  |  |  |  |  |
| Diabetes |  |  |  |  |  |

**DISABILITIES**

Are you registered disabled? Yes / No

*If Yes, please state date registered* ………………………………………

Are you registered blind? Yes / No

*If Yes, please state date registered* ……………………………..............

Are you registered partially sighted? Yes / No

*If Yes, please state date registered* ……………………………..............

Are you totally deaf/mute? Yes / No

Do you have a history of hearing problems? Yes / No

Do you wear a hearing aid? Yes / No

Do you have a physical disability? Yes / No

*If Yes, please give details* ………………………………………

Are you dependent on a wheelchair? Yes / No

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**SOCIAL INFORMATION**

What is your occupation? ……………………………………………………………….

**VETERANS**

Were you ever a member of the Armed Forces? Yes / No

*If Yes, what was your service or personnel number?* ……………………………..

*Date of enlistment in Armed Forces* ……………………………..

*Date of leaving Armed Forces* ……………………………..

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**CARERS**

Are you caring for someone? Yes / No

Or, is someone caring for you? Yes / No

What is the name of the person you are caring for? Or, what is the name of your carer?

Name …………………………………………………………… Date of Birth ………………………..

Are you happy for us to make an entry on your medical record to say that you are a carer /

have a carer? Yes / No Signed

……………………………….

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please insert the date you completed this questionnaire and return it to the surgery with your Registration Form

Date …………………………………………

Please make an appointment to see our Healthcare Assistant for a health check

Thank you

THIS INFORMATION WILL BE TREATED IN THE STRICTEST OF CONFIDENCE.

THANK YOU FOR YOUR CO-OPERATION

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