



Hay-on-Wye and Talgarth Medical Practice (GMS W96017) Patient Questionnaire

(NB all information supplied will be recorded in your confidential medical record)

FULL NAME TITLE

ADDRESS

.....POSTCODE

DATE OF BIRTH.....MARITAL STATUS.....

NHS number (if known).....HOME TEL.....

WORK TELMOBILE (if aged 16 and over).....
(provide if you are happy to be contacted on this number)

GENDER.....PREFERRED LANGUAGE.....

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 (please delete as appropriate)**

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 (please delete as appropriate)**

E-mail address.....

ETHNICITY:

Asian, Asian Welsh or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background

Black, Black Welsh, Black British, Caribbean or African

- ☐ Caribbean
- ☐ African
- ☐ Any other Black, Black British, or Caribbean background

Mixed or multiple ethnic groups

- ☐ White and Black Caribbean

- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed or multiple ethnic background

White

- ☐ Welsh, English, Scottish, Northern Irish or British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background

Other Ethnic group

- ☐ Arab
- ☐ Any other ethnic group

SMOKING

Do you smoke Current Smoker / Ex Smoker / Never

If Yes, how many: Cigarettes per day..... Ounces of tobacco per day.....

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

ALCOHOL INTAKE

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

Follow the link below to access more information including a guide to calculating your alcohol intake – Alcohol units – NHS (www.nhs.uk). Or you can use the Alcohol Change's calculator – Unit calculator | Alcohol Change UK

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

HEIGHT AND WEIGHT

Please tell us your most recent measurements for the following (if know)

Height:.....

Weight:.....

Please note, we may contact you to offer you support or advice if appropriate based on your submission. NB: The following information you supply may assist us to provide good care for you whilst we wait for your previous medical records.

Do you take any prescribed repeat medication? YES/NO

If YES, please provide an up to date repeat medication slip or a medication summary from your previous GP practice. If you cannot obtain this information speak to reception when you submit your registration pack.

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 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	

ALLERGIES Do you have any allergies? Yes / No

If Yes, please give details.....

BLOOD TRANSFUSIONS: Have you received a blood transfusion prior to 1996? Yes / No

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

CARERS

Do you need/have anyone who looks after you or your daily needs as a Carer Yes / No

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

(A member of reception staff can help with this arrangements)

Do you care for someone else?

Yes / No

(If Yes, please ask the reception staff about Carers support)

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

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?

.....
New patient health check appointment

Would you like to attend a new patient health check appointment with our Healthcare Assistant
Yes/No

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

Date

Thank you for completing this questionnaire

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