ST PETER'S SURGERY NEW PATIENT QUESTIONNAIRE

PLEASE COMPLETE THE WHOLE FORM AS MISSING INFORMATION WILL RESULT IN A DELAY IN YOUR REGISTRATION. ONCE ALL SECTIONS OF THIS QUESTIONNAIRE ARE COMPLETED AND RETURNED YOUR REGISTRATION WILL BE PROCESSED. THE INFORMATION YOU PROVIDE WILL BE TREATED IN THE STRICTEST CONFIDENCE.

DATE TODAY: ……..

FULL NAME: …….. DOB: ……

ADDRESS: ……

…… POSTCODE: ……..

HOME TEL NO: …….. MOBILE NO: ……

Have you previously been registered with us? YES / NO
ARE THERE ANY MEMBERS OF YOUR HOUSEHOLD REGISTERED HERE? YES / NO

If so please list their names:
……

MEDICATION

ARE YOU CURRENTLY TAKING REGULAR REPEAT MEDICATION? YES / NO
HAVE YOU PROVIDED YOUR REPEAT MEDICATION LIST? YES / NO

For patients whose previous Doctor's practice is outside of the Hywel Dda Area.
If you are unable to obtain your medication list because your previous Doctor's practice is outside of the Hywel Dda area, please list your medication below stating the dose you take of each tablet and provide the contact numbers for your previous Doctor's practice. **(You will need to contact your previous Doctor's practice for this information)**

Name of Drug: ……. Dose: ……

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Name of Drug: ……. Dose: ……

Name of Drug: ……. Dose: ……

Previous Doctor's Practice:

Telephone No: ……

Fax No: ……

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATION? YES /NO

If yes, please detail: …….

PAST MEDICAL HISTORY

Do you suffer from any of the following?
(Please Tick)

DIABETES	☐	CHRONIC RESPIRATORY DISEASE	☐
ASTHMA	☐	ATRIAL FIBRILLATION	☐
HEART DISEASE	☐	EPILEPSY	☐
HIGH BLOOD PRESSURE	☐		

Please give details of any important illnesses/operations:

Month: _____ Year: _____ Details: _____

Month: _____ Year: _____ Details: _____

Month: _____ Year: _____ Details: _____

Month: _____ Year: _____ Details: _____

DISABILITIES

Do you have any disability? YES / NO

Do you have any special requirements e.g. Hearing aid / wheelchair access / partially sighted?
If yes, please detail:

…….

LIFESTYLE

Are you: a smoker ☐ If yes, how may a day? ……..

an ex-smoker ☐ when did you stop smoking? ……

never smoked ☐

Do you drink alcohol? YES / NO If yes, how many units a week? ……

A unit of alcohol is approximately: **½ pint standard beer (3.5%) or 1/3 pint premium beer (5%)**
125ml wine
25ml spirits

FEMALE PATIENTS

HAVE YOU HAD A SMEAR TEST? YES / NO If yes, please give date of your most recent test: ……..

CARERS

A carer is someone who looks after a relative, friend or neighbour who is ill, frail, disabled, has a mental health concern or problematic substance use who could not manage without help. Do you care for a relative or friend? YES / NO Do you have a carer? YES / NO If yes, give name & contact detail: ……. Would you like to be referred for a carer needs assessment? YES / NO

EMERGENCY CONTACT DETAILS

This will be the person that the surgery contacts in case of Emergency		
TITLE: FIRST NAME:	SURNAME:	
Home Tel No:		
Mobile Tel No:		
Work Tel No:		
Relationship to You:		
Is this person also your next of kin?	YES ☐	NO ☐
Can this person discuss your medical records? **NB:** This person will have access to your appointments, results and other confidential information. You will contact the Practice if any of these details change.	YES ☐	NO ☐
Signature:	**Date:**	

A member of our administration staff will check that this form is complete, and ask you for proof of identity (e.g. passport/driving Licence) and proof of your address (e.g. utility bill/bank statement/ social security forms). Only then will you be offered an appointment for a New Patient Check.

At this appointment you will need to bring a urine sample. A pot can be obtained at the reception desk.

For Surgery Use Only

Form has been checked ☐ Identity Verified ☐

NAME: _____ SIGNATURE: _____