

**New Patient Questionnaire**

Date Completed: \_\_\_\_\_

You have just joined our practice, and it may be some months before your records reach us. Please answer the following questions to give your new GP a guide to your past medical history.

**Your Details:**

Name: _____	Date of Birth: _____
Address: _____	Postcode: _____
Email: _____	Contact Number: _____
Marital Status: _____	Occupation: _____
Preferred Language: Welsh <input type="checkbox"/> English <input type="checkbox"/>	Other: _____
Ethnicity/Ethnic Group: White <input type="checkbox"/> Black <input type="checkbox"/>	Indian <input type="checkbox"/> Chinese <input type="checkbox"/>
Other: _____	Prefer not to say <input type="checkbox"/>

**Next of Kin:**

Name: _____	Relationship to you: _____
Address: _____	Postcode: _____
_____	Contact Number: _____

**Have you ever been told you have any of the following conditions?**

High Blood Pressure	Yes / No	Date Diagnosed: _____	
Type 1 Diabetes	Yes / No	Date Diagnosed: _____	
Type 2 Diabetes	Yes / No	Date Diagnosed: _____	
Heart Disease	Yes / No	Date Diagnosed: _____	Details: _____
Mental Health Problems	Yes / No	Date Diagnosed: _____	Details: _____
Thyroid Disease	Yes / No	Date Diagnosed: _____	Details: _____

**Do you have any other medical problems that we need to be aware of at the moment?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medication

Please list below any regular prescribed medication (you can attach a repeat prescription list if easier)

Name of Medication	Dose	How often you take it

## Preferred Chemist:

Boots, Aberaeron

Allied, Aberaeron

Collect from Surgery

Posted (please provide stamped envelope)

Adrian Thomas, Lampeter

## Cervical Screening (females)

Date & result of your last cervical screening test: \_\_\_\_\_

Or Hysterectomy: \_\_\_\_\_

## Health Promotion

Do you smoke? Yes / No / Ex-Smoker  
If yes, how many per day? Cigarettes \_\_\_\_\_ Pipe \_\_\_\_\_ Cigars \_\_\_\_\_  
Would you like help quitting? Yes / No

Do you drink alcohol? Yes / No  
If yes, how much do you drink in a week? Beer \_\_\_\_\_ Wine \_\_\_\_\_ Spirits \_\_\_\_\_

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

## Carers Information

Are you a carer? (i.e. provide support and care for a relative who could not cope without it) Yes / No

Who do you care for? \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you have a carer? Yes / No Name of Carer: \_\_\_\_\_ Relationship: \_\_\_\_\_

Are you willing for us to share this information with Red Cross and Social Services? Yes / No

## Armed Forces Veterans

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

Have you recently been discharged from the Armed Forces? Yes / No

Do you have a copy of your MoD Medical Records? Yes / No