CANOLFAN IECHYD LLANGOLLEN HEALTH CENTRE

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NEW PATIENT REGISTRATION

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health, which will help in your future treatment. Patients may be asked to attend the practice for an initial consultation and some basic checks.

Your details:

Title:		Forename:	
Surname:		Previous Surname :	
Known as:		Date of birth:	
Address:			
Marital status:		NHS number: (compulsory)	
Home telephone no:		Mobile no:	
Email address*:		Occupation:	
Gender:		Gender at birth:	
Preferred written language:		Preferred spoken language:	
Is an Interpreter required?	YES / NO	Religion:	

*By providing your email address, you are consenting to us contacting you via email

Ethnicity (please select from the categories in italics):

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	

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?	
Have you ever served in the Armed Forces?	YES / NO
If yes, please state which	
Do you consent to the practice contacting you by text message or email 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

Next of kin:

Name of next of kin:		Relationship to patient:	
Telephone no:		Email address:	

Smoking*:

Do you smoke?	YES / NO
If yes, how many?	Cigarettes per day:
	Grams of tobacco per week:

Alcohol*:

How many units of alcohol do you drink a week?	

Please answer to the best of your knowledge. For guidance:
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

More information including a guide to calculating your alcohol intake can be found at:
www.alcoholchange.org.uk/alcohol-facts/interactive-tools/unit-calculator
or
www.nhs.uk/live-well/alcohol-advice/calculating-alcohol-units

Height & weight*:

Please tell us your most recent height measurement	
Please tell us your most recent weight measurement	

*We may contact you to offer support and advice based on your answers

Medical history:

Do you have, or do you have a family history of (father, mother, brother, sister, maternal grandmother/father, paternal grandmother/father) any of the following conditions? Please give details below.			
	Do you have this condition?	Does a family member have this condition?	State family member's relationship to you (e.g. mother)
Rheumatoid Arthritis			
Psoriasis			
Eczema			
Diabetes			
Ulcerative colitis			
Dementia			
COPD			
Peripheral arterial disease			
Kidney disease			
Atrial fibrillation			
Crohn's disease			
High blood pressure			
Depression			
Osteoporosis			
Thyroid disease			
Stroke / TIA			
Heart disease inc. heart attack or heart failure			
Epilepsy			
Asthma			

If you have or have had cancer, please give details below	
Site of cancer:	
Approx. date of diagnosis	

If a family member has, or has had, cancer, please give details below	
Site of cancer:	
Relationship to you (e.g. mother)	

Have you received a blood transfusion prior to 1996?	YES / NO

Are you attending hospital at the moment?	YES / NO (If yes, please give details below)
If there are any other medical conditions or treatments you wish to make us aware of, please use the box below	

Allergies:

Do you have any allergies?	YES / NO
If yes, please give details	

Medication:

Please list below any medication you take*	
Name of drug	Dosage

*To avoid any delay in processing your prescriptions, if you are on repeat medications, please provide us with your repeat prescription slip

Carers:

Do you have anyone who looks after you or your daily needs as a carer?	YES / NO
If yes, is this person a relative, friend, neighbour or other?	
Would you like your carer to deal with your health affairs here?	YES / NO
What is your carer's name?	

Do you help look after someone as a carer*?	YES / NO
If yes, is this a relative, friend, neighbour or other?	
What is the name of the person you care for?	

*Please ask at reception for information on carer's support.

Please provide the name and address of your previous Doctor's Surgery:

Practice Name:	
Practice Address:	

Would you like a copy of our Practice Leaflet emailing to you? Alternatively, you can access information about the practice and our services at **www.llangollenhealth.com**	YES / NO

Electronic Prescription Service (EPS):

Instead of printing and signing paper prescriptions, our staff will send them electronically to the pharmacy that you choose, safely and securely. The pharmacy that you ask us to send your prescriptions to electronically is called your "EPS nomination".

Have you ever had an EPS nomination at a pharmacy or DAC* in England (where your prescription was sent electronically)?	YES / NO / NOT SURE
If you have had a previous EPS nomination that is no longer active (e.g. because you have moved) this is called a legacy nomination. Do you consent to any legacy nominations being removed from your patient record?	YES / NO
Now that you are joining our practice, which pharmacy would you like to be your EPS nomination? Please specify name of pharmacy and location e.g. Rowlands Pharmacy, Llangollen or Alexanders Pharmacy, Plas Madoc.	
If you have any dispensing appliances on your prescription (e.g. catheters, stoma products, food supplements etc.) please nominate the company that supplies you with these (e.g. Vyne, Coloplast etc.)	

Thank you