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**Meddygfa Geli Onn/Ashgrove Medical Centre**

**FAO Reception Staff** – please ensure the form is completed correctly and includes the **NHS number** for the patient, for all patients **under 18 years of age** a copy of their immunisation history (from the patient’s current practice). **Reception Verification**: \_\_\_\_\_\_\_\_\_\_

**Dear Patient, please tick your selection or reply to each question with yes or no.**

**MAKE EVERY CONTACT COUNT – ONE STOP APPROACH**

**PATIENT INFORMATION QUESTIONNAIRE (PIQ2)**

**IF YOU REQUIRE ASSISTANCE TO COMPLETE THIS QUESTIONNAIRE – PLEASE ASK AT RECEPTION.**

All information provided in this questionnaire will be treated in the strictest confidence and in accordance with the Data Protection Act (DPA) 1998 and General Data Protection Regulation (GDPR) 2018.

**WE CANNOT COMPLETE THE REGISTRATION PROCESS IF YOU HAVE NOT SIGNED AND COMPLETED THE QUESTIONNAIRE IN FULL.**

SURNAME: FIRST NAME:

DOB: NHS No.:

ADDRESS:

CONTACT DETAILS: (By providing us with your Mobile telephone number and email you are consenting to us contacting you via SMS message and email).

HOME: MOBILE:

EMAIL:

Preferred Language Written and Spoken

Legal Next of Kin (NOK):

Relationship of Legal NOK:

Address of Legal NOK:

Emergency Contact Telephone:

|  |
| --- |
| **ETHNIC ORIGIN: I would describe my ethnic origin as (please tick)** |
| **WHITE:** | **MIXED/MULTIPLE ETHNIC GROUPS:** | **ASIAN/ASIAN BRITISH** |
| British (Welsh/English/Scottish/Northern Irish) |  | White & Asian |  | Bangladeshi |  |
| Irish |  | White and Black African |  | Chinese |  |
| Gypsy or Irish Traveller |  | White and Black Caribbean |  | Indian |  |
| Any other white/ethnic background  |  | White and Chinese |  | Pakistani |  |
|  |  | Any other Mixed/Multiple |  | Any other Asian background |  |
| **OTHER:** |
| AFRICAN |  | ARAB |  | CARIBBEAN |  |
| ANY OTHER ETHNIC GROUP |  | ANY OTHER BLACK BACKGROUND |  |  |  |
| **WHAT IS YOUR FAITH OR RELIGION, IF ANY?** |
| No religion or belief |  | Hindu |  | Sikh |  |
| Buddhist |  | Jewish |  | Any Other religion/belief |  |
| Christian |  | Muslim |  | Prefer not to say |  |
| **WHAT IS YOUR SEXUAL ORIENTATION?** |
| Bisexual |  | Heterosexual/Straight |  | Prefer not to say |  |
| Gay/Lesbian |  | Other |  |  |  |
| **WHICH GENDER DO YOU INDENTIFY WITH?** |
| MALE |  | FEMALE |  | OTHER PREFERRED DESCRIPTION |  | PREFER NOT TO SAY |  |
|  |  |  |  |  |  |  |  |
| Are you a HM Forces Military Veteran? (**13Ji**) |  |  |  |  |
| Are you a Student? |  | Student No.  |  |  |  |
| Have you been in HM Prison |  |  |  |  |  |
| Are you a care Home/Nursing Home/EMI Resident and subjected to a Deprivation of Liberty Standards (DOLS) (**9NgzG**): Active 🞎 Expiry Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lapsed 🞎 Pending 🞎  |  |
| Is this the first time you have registered with a GP in the UK? |  | Date you entered the UK: |  |
| Are you an Asylum Seeker |  |  |  |  |  |

**DO YOU HAVE A CARER? Yes (918f)** 🞎 **No** 🞎

**ARE YOU AN UNPAID CARER?**

**Do you look after someone for longer than 14 hours per week? Yes (918G)** 🞎 **No** 🞎

Looking after an elderly parent, disabled relative, partner or friend, a child with special needs

Please indicate who you care for: Parent 🞎 Child 🞎 Relative 🞎 Partner 🞎 Friend 🞎

**Please list all family members living at the same address as yourself and their relationship to yourself:**

NAME: RELATIONSHIP:

Do you have any known **ALLERGIES**? YES 🞎 NO 🞎

If yes please give further details:

Are you taking any **REPEAT MEDICATION**? YES 🞎 NO 🞎

If **yes** please list the medication, dose and instruction below, or attach the right-hand side of a recent prescription?

**NHS Wales App** is an online service brought to you from Digital Health Care Wales. NHS Wales App offers patients the convenience to book appointments using the internet and you will be able to order repeat prescriptions online. The App is a simple and secure way to: book routine appointments, order repeats and view parts of your medical record. To access the App you must have a fully verified NHS Login, or a valid photo ID to prove who you are and be aged 16 or over. Download the App today or use the desktop web version available. Find out more at:

Login page [Login screen (nhs.wales)](https://app.nhs.wales/login)

Help page [NHS login - NHS Wales App](https://apphelp.nhs.wales/help/nhs-login/)

Please list any known **VACCINATIONS** you have had, and the date that they were administered?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Vaccination | Date | Vaccination | Date | Vaccination | Date |
| Diptheria |  | Polio |  | German Measles |  |
| Tetanus |  | Typhoid |  | Measles |  |
| Cholera |  | BCG |  | Yellow Fever |  |
| MMR |  | Whooping Cough |  | Meningitis C |  |

**CHRONIC DISEASES** – have you been diagnosed with any of the following, please tick all that apply (please state date of diagnosis): -

|  |
| --- |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Coronary Heart Disease** (CHD) (**G3)** |  | **Heart Failure (HF)** – (**G58)** |  | **Atrial Fibrillation (AF)** (**G5730)** |  |
| **Hypertension (G20)**(High Blood Pressure)  |  | **Ischaemic Heart Disease** (IHD) (**G31)** |  | **COPD** (**H3**)  |  |
| **Asthma** (**H33)**   |  | **Chronic Kidney Disease** Stage 3 (**1Z12)** |  | **Cystic Fibrosis** (**C370)** |  |
| **Down’s Syndrome** (**PJ0)** |  | **Fragility Fracture +75** (**N331N)** |  | **Hypothyroidism** (**C04)** |  |
| **Epilepsy** (**F25)**  |  | **Obesity (BMI) > 30** (**22K)** |  | **Rheumatoid Arthritis** (**N040)**  |  |
| **Iron Deficiency Anaemia’s** (**D00**) |  | **Vitamin D Deficiency** (**C28)**  |  | **Vitamin B12 Deficiency** (**C2621)**  |  |
| **Bronchiectasis** (**H34)** |  | **Dementia** (**Eu00)** |  | **Stroke and TIA** (**G61)** |  |
| **Osteoporosis** (**N330)**  |  | **Hyperlipidaemia** (**C322)** **Hyperlipidaemia NOS (C324)** |  | **Diabetes Mellitus:** * Type 1 **C10E**
* Type 2 **C10F**
 |  |
|  |
|  |
| **Learning Difficulties** **(E3) Type** of condition: | **Mental Health** (**MH**): |
| * Speech & language disorder
 |  | * Schizophrenia (**Eu2)**
 |  |
| * Global development delay
 |  | * Bipolar **(Eu31 )**
 |  |
| * Motor skills development delay
 |  | * Non Organic Psychoses **(E1 )**
 |  |
| * Learning Difficulties
 |  | * Severe Depression **(Eu32)**
 |  |
|  |  | * Depression **(Eu32)**
 |  |
| **CANCER**/Malignancy neoplasm: Sarcoidosis (**AD5)** Please specify organ : |  | * Anxiety with Depression **(E2003)**
 |  |
|  | * Anxiety States **(E200)**
 |  |
|  |  |  |
| **Are you registered as disabled of affected by sensory impairments?****(If yes please state the impairment)?** |

|  |  |  |  |
| --- | --- | --- | --- |
| No |  | Yes -  |  |

**Family History (Code as FH: IHD etc.)**

|  |  |
| --- | --- |
| Please state any serious illness, in particular heart disease, strokes, high blood pressure, breast cancer, bowel cancer, prostate cancer, ovarian cancer, diabetes or any inherited disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Please state: Relationship and Age\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SCREENING**

Have you received an invitation for Bowel Screening? NO 🞎 YES 🞎 If yes please note

 Date: Result:

Have you received an invitation for Aortic Aneurysm Screening? NO 🞎 YES 🞎 If yes please note

 Date: Result:

**FEMALE PATIENTS ONLY**

Have you received an invitation for Breast Screening? NO 🞎 YES 🞎 If yes please note

 Date: Result

**ALL FEMALE PATIENTS**

Have you given birth? NO 🞎 YES 🞎

If yes please note ages and sex of children.

Have you had a Hysterectomy? NO 🞎 YES 🞎 If yes please note date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had Cervical Smear Test (aged between 25-60) YES 🞎 NO 🞎

If yes please give date of last Smear: Was the result normal: YES 🞎 NO 🞎

**Do you have a Registered Lasting Power of Attorney (LPA) in force?** YES 🞎 NO 🞎

A health and welfare LPA gives your attorney the power to make decisions about your daily routine (washing, dressing, eating), medical care, moving into a care home and life-sustaining medical treatment. It can only be used if you're unable to make your own decisions. A lasting power of attorney has to be registered before it comes into force.

Name of your Nominated Attorney:

Contact Details for the Attorney:

Address & Telephone Number:

Date LPA Registered:

**SMOKING STATUS**: Do you smoke? YES 🞎 NO 🞎

If yes please state what you smoke, how much, and how often you smoke:

**GET THE BENEFITS AND SUPPORT FOR STOPPING SMOKNG ‘CONVERT INTO A QUITTER’ AND REAP THE REWARDS OF A HEALTHIER LIFESTYLE. YOU’RE NOT ALONE ON THIS JOURNEY.**

**STOP SMOKING WALES 0800 085 2219/www.helpmequit.wales**

**ALCOHOL/DRUG QUESTIONNAIRE:** Please tick the number that applies to you.

(1 Unit = 1 glass of wine or ½ pint of beer)

|  |  |  |
| --- | --- | --- |
| **1. How often do you have a drink containing Alcohol?** |  | **2. How many units of alcohol do you have on a typical day when you are drinking?** |
| Never |  |  | 1 to 2 |  |
| Monthly or less |  |  | 3 to 4 |  |
| 2-4 times a month |  |  | 5 to 6 |  |
| 2-3 times a week |  |  | 7 to 9  |  |
| 4 or more times a week |  |  | 10 or more |  |
|  |  |  |  |  |
| **3. How often have you had 6 or more units if female, or 8 or more if male on any single occasion in the last year?** |  | **4. How often during the last year have you found that you were not able to stop drinking once you had started?** |
| Never |  |  | Never |  |
| Less than monthly |  |  | Less than monthly  |  |
| Monthly |  |  | Monthly |  |
| Weekly |  |  | Weekly |  |
| Daily or almost daily |  |  | Daily or almost daily |  |
|  |  |  |  |  |
| **5. How often during the last year have you failed to do what was normally expected from you because of your drinking?** |  | **6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going?** |
| Never |  |  | Never |  |
| Less than monthly |  |  | Less than monthly |  |
| Monthly |  |  | Monthly |  |
| Weekly |  |  | Weekly |  |
| Daily or almost daily |  |  | Daily or almost daily |  |
|  |  |  |  |  |
| **7. How often during the last year, have you had a feeling of guilt or remorse due to your drinking?** |  | **8. How often during the last year have you been unable to remember what happened the night before because you have been drinking?** |
| Never |  |  | Never |  |
| Less than monthly |  |  | Less than monthly |  |
| Monthly |  |  | Monthly |  |
| Weekly |  |  | Weekly |  |
| Daily or almost daily |  |  | Daily or almost daily |  |

|  |
| --- |
| **ALCOHOL/DRUG QUESTIONNAIRE CONTINUED:** |
| **9. Have you or someone else been injured as a result of your drinking?**  |  | **10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?** |
| No  |  |  | No |  |
| Yes |  |  | Yes, but not in the past year |  |
|  |  |  | Yes, during last year |  |
| **Have you ever used street (recreational) drugs? (If yes please state what type?)** |  |  |  |
| No |  |  |  |  |
| YesWhat Type? |  |  |  |  |
|  |  |  |

**PHYSICAL ACTIVITY (**please tick the answer that applies to you**)**

|  |  |  |
| --- | --- | --- |
| **1. I am not in Employment e.g.** |  | **2. I spend most of my time sitting e.g. within an office environment** |
| Retired |  |  | Yes  |  |
| Retired for Health Reasons |  |  | No |  |
| Full Time Carer |  |  |  |  |
| Unemployed |  |  |  |  |
| **3. I spend most of my time at work standing or walking, however, my work does not require much intense effort e.g.** |  | **4. My work involves definite physical effort including handling of heavy objects and use of tools e.g.** |
| Shop Assistant |  |  | Plumber  |  |
| Hairdresser |  |  | Electrician |  |
| Security Guard |  |  | Carpenter |  |
| Childminder |  |  | Cleaner |  |
| Other  |  |  | Hospital Nurse |  |
|  |  |  | Gardener |  |
| **5. My work involves physical activity including handling of very heavy objects e.g.** |  | Postal Delivery Worker |  |
| Plumber  |  |  | **6. My work involves vigorous physical activity including the handling of very heavy objects e.g.** |
| Electrician |  |  | Scaffolder |  |
| Carpenter |  |  | Construction Worker |  |
| Cleaner |  |  | Refuse Collector |  |
| Hospital Nurse |  |  |  |  |
| Gardener |  |  |  |  |
| Postal Delivery Worker |  |  |  |  |
|  |  |  |  |  |
| **7. During the week, how many hours do you spend on exercising e.g. swimming, jogging, aerobics, football, tennis, gym workout?**  |  | **8. Physical Exercise such as cycling to work and during leisure time etc.** |
| Employed |  | Not Employed |  |  | None |  |
| None |  |  | Some but less than 1 hour |  |
| Some but less than 1 hour |  |  | 1 hour but less than 3 hours |  |
| 1 hour but less than 3 hours |  |  |  |  |
| 3 hours or more |  |  |  |  |
| **9. Physical Exercise such as walking including walking to work, shopping for pleasure etc.** |  | **10. Housework/Childcare** |
| None |  |  | None |  |
| Some but less than 1 hour |  |  | Some but less than 1 hour |  |
| 1 hour but less than 3 hours |  |  | 1 hour but less than 3 hours |  |
| 3 hours or more |  |  | 3 hours or more |  |
| **11. Gardening/DIY** |  | **12. Please state your walking pace** |
| None |  |  | Slow Pace |  |
| Some but less than 1 hour |  |  | Steady Average Pace |  |
| 1 hour but less than 3 hours |  |  | Brisk Pace |  |
| 3 hours or more |  |  | Fast Pace |  |
|  |  |  |  |  |
| **For Office Use Only – Practice Read Codes** |  |  |  |
| Inactive (138X) |  | Mod. Inactive (138Y) |  | Mod. Active (138a) |  | Active (138b) |  |
| **Do you eat sensibly, for example by cutting down on fatty foods and eating more fresh fruit and vegetables? Would you describe your diet as (Go on be honest!!)?** |
| Good |  | Moderate |  | Poor |  |
| WOULD YOU LIKE A CONSULTATION WITH OUR HEALTHY LIVING ADVISOR? | **YES** |  | **NO** |  |

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM**

**Please note that we do not tolerate violence or abuse directed at our staff. Abusive and violent patients will be removed from the practice list.**

**PATIENT’S DECLARATION:**

**I believe all the information provided to be correct as reasonably practical and hereby give consent for data activity and contact in accordance with GDPR and Medical Act.**

**Signature of Patient or Patient’s Guardian:**

**Date:**