

**LLYS MEDDYG SURGERY**  
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**NEW PATIENT HEALTH QUESTIONNAIRE**

Thank you for registering with us at Llys Meddyg Surgery. We hope that you will find us helpful and efficient in the service we offer you. As it sometimes takes a while for GP records to be delivered from your previous practice, we would like to offer you an appointment with one of our practice nurses for a 'new patient registration check'. This gives us a chance to record your basic health background so that we have as much information to help us care for you until your medical records arrive. The information provided will assist also in the identification of people needing long term management of their medical conditions, and ensure that we can focus our care and advice on your health needs.

Your appointment is on (day).....(date).....(time).....am/pm

It would greatly assist us if you could complete this questionnaire and return it with your registration form or bring it with you for your registration appointment.

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Your full name:.....

Date of Birth:.....

Status (circle as appropriate): Single/Married/Widowed/Divorced/Separated/  
Co-habiting/Other (please state) .....

Place of birth: ..... Previous GP and surgery: .....

Occupation: .....

If schoolchild, name of school: .....

No and ages of children:.....  
*Or if the patient is a child, number and age of siblings*

Are you living in a childrens home, with foster parents or in a residential school named in your statement of Special Educational need or other accommodation arranged by a local authority or LHB?

If Yes, please state which:.....

Next of Kin..... Relationship.....

Contact details of Next of Kin.....

**MEDICATION**

Are you on any regular medication? If so, please list below (or attach your prescription reminder from your old practice)

.....  
.....  
.....

If you are on medication that requires regular blood tests i.e. warfarin, Methotrexate

Please state:..... When was your last blood test: Date .....

Do you have any of the following, and if so when did you last have your injection:

Zoladex Date:..... B12 Date: ..... Depo Provera Date: .....

Do you have any medication or other allergies? .....

**PAST MEDICAL HISTORY**

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Have you ever had any serious illness? If so what and when?

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**PAST SURGICAL HISTORY**

Have you had any operations? If so, what and when?

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Have you had a Pneumonia Injection? Yes/No If yes, when? Date approx:.....

**SMOKING**

Do you smoke? Yes/No/Ex. If Yes, how many per day?.....

**WEIGHT AND HEIGHT**

Approx Weight: ..... Approx Height: .....

**ALCOHOL**

How many units of alcohol do you drink each week? .....  
(1unit = half pint of beer, 1 glass of wine, or a pub measure of spirits)

**DIET**

Do you have a diet that includes milk, meat, vegetables and fruit? Yes/No

If No, please state type of diet followed .....

Do you add salt to your food after cooking? .....

**EXERCISE**

How many minutes for at a time?..... How many times a week?.....

**FAMILY HISTORY**

Is there any of the following in your family? (*father, mother, brother, sister, grandparent*)

	<b>Yes/No</b>	<b>Which family member?</b>	<b>Age when affected?</b>
<b>Heart disease (heart attacks, angina, etc)</b>			
<b>Stroke?</b>			
<b>Diabetes?</b>			
<b>High blood pressure?</b>			
<b>Epilepsy?</b>			
<b>Thyroid problems?</b>			
<b>Respiratory problems eg asthma/COPD?</b>			
<b>Liver disease?</b>			

<b>Kidney disease?</b>			
<b>Mental Health Problems?</b>			
<b>Cancer?</b>			
<b>Any other significant illness? What?</b>			

Are you concerned about your health in any way or is there anything in particular you would like to discuss further with a member of the practice team?

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**FEMALES ONLY**

Have you had a smear test; if so when and what was the result?	
Have you had a mammogram; if so, approximately when?	
Have you had a rubella injection (german measles)?	
Current method of contraception	

**Do you have a disability?** Yes/No (If yes, please indicate with a tick below)

What is the nature of your disability?

- Dyslexia.....
- Mobility (walking disabilities).....
- Mental health difficulty.....
- Blind/partially sighted.....
- Progressive disability/chronic disability (eg MS, Cancer) .....
- Deaf/hearing loss .....
- Learning Disability .....
- Multiple Disabilities.....
- Other.....

**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

Do you care for anyone else? Yes/No  
*If "Yes", ask at reception about initiatives for Carers support locally*

Please indicate your ethnic origin. **This is not compulsory**, but may help with your healthcare as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Please tick the relevant box which best suits you:

White	
Mixed	
Asian or Asian British	
Black or Black British	
Chinese or other Ethnic Group	
Declined/Not Given	

Are there any other clinical requirements that may help us to provide the best care for you?

Please state:

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***Thank you for taking time to complete this questionnaire. It will save considerable time when you attend for your registration appointment.***