Meddygfa Waunfawr

Date Form Completed:	

PATIENT HEALTH QUESTIONNAIRE (FOR ADULTS 16 YEARS +)					
TITLE:		**FIRST NAME:**			
SURNAME:					
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)		
HOME TEL:		**WORK TEL:**		**MOBILE TEL:**	
EMAIL ADDRESS:					
NEXT OF KIN: **(Name, Address, Tel No.)**					
I CONSENT TO RECEIVING NOTIFICATIONS FOR CLINICAL SERVICES VIA SMS MESSAGE, VOICEMAIL, E-MAIL AND LETTER:	**YES** ☐ **NO** ☐ (please tick)				
ARE YOU A CARER FOR SOMEONE? **If yes, please specify:**	**YES** ☐ **NO** ☐ (please tick)				
ARE YOU NEW TO THIS COUNTRY? From the EEA? **(#13D3) If yes, please specify country of origin, and what line of work you are in:**	**COUNTRY:** **WORK:**				

GENERAL HEALTH INFORMATION				
	Height:	**Ft** **Inches /** **Metres**		
	Weight:	**St** **Pounds /** **Kg**		
Are you a current smoker? **YES** ☐ **NO** ☐ (please tick)	**If Yes**		**If No**	
	No. Cigarettes per day?		**Have you ever smoked?**	
	No. Cigars per day?		**If yes, what year did you stop?**	
	Pipe tobacco per week? (oz / grams)		**How many *did* you smoke per day?**	
	Would you like help and information on how to	**YES** ☐ **NO** ☐		

	stop? If so, please ask at reception	
Do you drink alcohol?	**YES** ☐ **NO** ☐ (please tick)	
If Yes: Wines / Spirits: units per week		
Beer: units per week		
1 unit = 1 small glass of wine or 1 single measure of spirit or one half pint of (standard strength) beer		
Would you like Lifestyle Advice? (If Yes, arrange Appointment)	**YES** ☐ **NO** ☐ (please tick)	

MEDICATION	
ARE YOU ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ **DONT KNOW** ☐ (please tick)
If Yes, please state type and name:	

BLOOD PRESSURE	
If you're over 40, have you had your blood pressure checked in the last 12 months?	**YES** ☐ **NO** ☐ (please tick)
If No: Please ask our reception staff to arrange an appointment with the practice nurse.	

Asthma	
Are you Asthmatic?	**YES** ☐ **NO** ☐ (please tick)
If yes, dose it cause you night time symptoms?	**YES** ☐ **NO** ☐ (please tick)
Any daytime symptoms?	**YES** ☐ **NO** ☐ (please tick)
Is asthma limiting your activities?	**YES** ☐ **NO** ☐ (please tick)
If you would like your asthma treatment reviewed, please ask our reception staff to arrange an appointment with the practice nurse.	

WOMEN ONLY	
Date of Last Smear? If known.	

Vaccinations			
Have you been vaccinated with any of the following?			
Influenza	**YES** ☐ **NO** ☐ (please tick)	**MMR**	**YES** ☐ **NO** ☐ (please tick)
Pneumonia	**YES** ☐ **NO** ☐ (please tick)		
Shingles	**YES** ☐ **NO** ☐ (please tick)		
If No and you would like any of the above: Please ask for more information from our reception staff who can arrange an appointment with the practice nurse, if appropriate.			

MEDICAL HISTORY

Do you have/have you had any of the following conditions? (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
If Asthmatic, have you used your inhaler in past 12 months?	**YES** ☐ **NO** ☐		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations you have had :

	Date:
	Date:
	Date:
	Date:

FAMILY HISTORY

Has a first degree relative (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐
If Yes, Please give details:

Please give details of the current state of your family's health:

	Age	**State of Health**	**Age at death**	**Cause of Death**
Father				
Mother				
Sibling(s)				

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the practice

NAME _____ **DOB** _____

What is your main language? | |

Do you need an interpreter or sign language support? **Yes** ☐ **No** ☐

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
Scottish	
English	
Welsh	
Northern Irish	
British	
Irish	
Gypsy/Traveller	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian Scottish, or Asian British	
Pakistani, Pakistani Scottish, or Pakistani British	
Indian, Indian Scottish or Indian British	
Bangladeshi, Bangladeshi Scottish, or Bangladeshi British	
Chinese, Chinese Scottish, or Chinese British	
Other Asian, please specify:	

D. African	
African, African Scottish, or African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean Scottish, or Caribbean British	
Black, Black Scottish, Black British	
Other Caribbean or Black, please specify:	

F. Other ethnic group	
Arab	
Other, please specify:	

If you would prefer not to provide this information, please tick here:	
If you don't know your ethnicity, please tick here:	