***Brecon Medical Group Practice***

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**OVER 16s QUESTIONNAIRE**

**If you are a new patient to the practice,** each member of the household must complete a form. Please note there is a **different form for patients aged under 16.**

To be completed in conjunction with Form GMS1W (Family Doctor Services Registration)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | | | | |
| **Surname:** | | | | **Forename(s):** | | | | |
| **Address:**  **Postcode:** | | | | | | | | |
| **Telephone Contact Details:** | | | | **Landline:**  **Mobile:** | | | | |
| **Email Address:** | | | |  | | | | |
| **Date of Birth:** | | | | Please circle**: Male/Female:** | | | | |
| **Ethnicity** (Please circle appropriate option): | | | | **White / Black / Nepalese / Asian**  **Chinese / Eastern European**  **South American / Mixed Race / Other** | | | | |
| **First Language if applicable:** | | | | | | | | |
| **Are you a veteran of the armed forces? Yes / No** | | | | | | | | |
| **Emergency Contact** | | | | | | | | |
| **Name:** | | | |  | | | | |
| **Relationship to patient:** | | | |  | | | | |
| **Telephone Contact Details:** | | | |  | | | | |
| **Allergies** | | | | | | | | |
| **Please state any known allergies:** | | | |  | | | | |
| **Carer Information** | | | | | | | | |
| Are you a carer? (please circle) | | | | **Yes/No** | | | | |
| If so for whom? | | | |  | | | | |
| Do you have a carer? (please circle) | | | | **Yes/No** | | | | |
| **Do you have any disability needs & requirements you would like to make the practice aware of?** | | | | | | | | |
| Partially sighted?  (please circle) | | | **Yes/No** | | | | | |
| Hard of hearing?  (please circle) | | | **Yes/No** | | | | | |
| Other: | | |  | | | | | |
| **Medication (new patients only)** | | | | | | | | |
| **If you are a new patient on repeat medication, please supply a copy of your right hand side listing repeat medications.** | | | | | | | | |
| **Smoking Status** | | | | | | | | |
| Have you ever smoked tobacco? (please circle) | | | | | | **Yes/No** | | |
| Ex-smoker. How long since you smoked? (please circle and state) | | | | | | **Yes/No** | | |
| Smoker. How many do you smoke? (please circle and state) | | | | | | **Yes/No** | | |
| **Would you like help to quit smoking? please circle)** | | | | | | **Yes/No** | | |
| **Alcohol Consumption** | | | | | | | | |
| How many units do you consumer per week?  For example: Small glass of wine = 1 unit, One pint of Beer = 2 units, Alcopop = 1.5 units, Can of super strength lager= 4 units. | | | | | |  | | |
| **Exercise/Level of activity (please tick boxes provided)** | | | | | | | | |
| **Inactive** (*sedentary job and no physical exercise or cycling*) 🞏  **Moderately inactive** (*sedentary job and some but less than one hour of physical exercise and/or cycling per week or standing job and no physical exercise or cycling)* 🞏  **Moderately active** *(sedentary job and 1 to 2.9 hours of physical exercise and/or cycling per week or standing job and some but less than 1 hour of physical exercise and/or cycling per week or physical job and no physical exercise or cycling)* 🞏  **Active** *(sedentary job and 3 hours or more of physical exercise and/or cycling per week or standing job and 1 to 2.9 hours of physical exercise and/or cycling per week or physical job & some but less than 1 of physical exercise and/or cycling per week or heavy manual job)* 🞏 | | | | | | | | |
| **Health** | | | | | | | | |
| **Have you ever suffered from any of the following?** | | | | | | | | |
| **Chronic Disease** | **Yes/No** | **Date of Diagnosis** | | | **Chronic Disease** | | **Yes/No** | **Date of Diagnosis** |
| High Blood Pressure |  |  | | | Epilepsy | |  |  |
| Angina |  |  | | | Diabetes | |  |  |
| Asthma |  |  | | | Chronic Airways Disease | |  |  |
| **Family History** | | | | | | | | |
| History of Diabetes  Family Member: | | | | | | **Yes/No** | | |
| History of Heart Disease under 60  Family Member: | | | | | | **Yes/No** | | |
| History of Heart Disease over 60  Family Member: | | | | | | **Yes/No** | | |
| History of Stroke  Family Member: | | | | | | **Yes/No** | | |
| History of Cancer:  Family Member:  Type of Cancer (if known): | | | | | | **Yes/No** | | |

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| --- | --- |
| **Thank you for your time in completing this questionnaire.** | |
|  | |
| **ADMINISTRATION USE ONLY** | **DATE** |
| Form Scanned: |  |
| Task sent to GP to review form and ask whether appointment required to be seen: |  |