GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

NEYLAND & JOHNSTON MEDICAL PRACTICE

FAO Reception Staff – please ensure the form is completed correctly and includes the **NHS number** for the patient, take a copy of the patient's **proof of identity & address**, and 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. You will be required to supply proof of your address when registering with the surgery e.g. drivers licence & recent utility bill. Failure to provide information could delay your registration process and affect access to prescriptions and specialist diagnostic tests.

MAKE EVERY CONTACT COUNT – ONE STOP APPROACH

PATIENT INFORMATION QUESTIONNAIRE (PIQ2)

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.

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

PREFERRED PRONOUNS e.g.: he/him, they/them, she/her	

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?

_____

_____

_____

MY NHS WALES APP – WILL REPLACE MY HEALTH ONLINE FROM 31ST MARCH 2024. THIS WILL ALLOW YOU TO ACCESS A RANGE OF SEVICES INCLUDING ORDERING REPEAT MEDICATION. IF YOU HAVE ALREADY REGISTERED FOR A COVID PASSPORT, YOU WILL ALREADY HAVE ACCESS TO THE APP. IF YOU HAVE NEVER ACCESSED THE COVID PASSPORT, ALL YOU WILL NEED TO DO IS DOWNLOAD THE APP AND REGISTER USING YOUR NHS NUMBER.

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/vape? YES ☐ NO ☐ Please specify. _____

If yes please state what you smoke/vape, how much/ how often do you smoke/vape: _____

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
OR IF YOU WOULD LIKE HELP TO STOP SMOKING, PLEASE ASK RECEPTION TO REFER YOU TO OUR PRACTICE SMOKING CESSATION ADVISOR.

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?	
Never	
Monthly or less	
2-4 times a month	
2-3 times a week	
4 or more times a week	

2. How many units of alcohol do you have on a typical day when you are drinking?	
1 to 2	
3 to 4	
5 to 6	
7 to 9	
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?	
Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

4. How often during the last year have you found that you were not able to stop drinking once you had started?	
Never	
Less than monthly	
Monthly	
Weekly	
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?	
Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going?	
Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

7. How often during the last year, have you had a feeling of guilt or remorse due to your drinking?	
Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

8. How often during the last year have you been unable to remember what happened the night before because you have been drinking?	
Never	
Less than monthly	
Monthly	
Weekly	
Daily or almost daily	

ALCOHOL/DRUG QUESTIONNAIRE CONTINUED:

9. Have you or someone else been injured as a result of your drinking?	
No	
Yes	

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	
No	
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	
Yes What Type?	

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

1. I am not in Employment e.g.	
Retired	
Retired for Health Reasons	
Full Time Carer	
Unemployed	

2. I spend most of my time sitting e.g. within an office environment	
Yes	
No	

3. I spend most of my time at work standing or walking, however, my work does not require much intense effort e.g.	
Shop Assistant	
Hairdresser	
Security Guard	
Childminder	
Other	

4. My work involves definite physical effort including handling of heavy objects and use of tools e.g.	
Plumber	
Electrician	
Carpenter	
Cleaner	
Hospital Nurse	
Gardener	
Postal Delivery Worker	

5. My work involves physical activity including handling of very heavy objects e.g.	
Plumber	
Electrician	
Carpenter	
Cleaner	
Hospital Nurse	
Gardener	
Postal Delivery Worker	

6. My work involves vigorous physical activity including the handling of very heavy objects e.g.	
Scaffolder	
Construction Worker	
Refuse Collector	

7. During the week, how many hours do you spend on exercising e.g. swimming, jogging, aerobics, football, tennis, gym workout?			
Employed		Not Employed	
None			
Some but less than 1 hour			
1 hour but less than 3 hours			
3 hours or more			

8. Physical Exercise such as cycling to work and during leisure time etc.	
None	
Some but less than 1 hour	
1 hour but less than 3 hours	

9. Physical Exercise such as walking including walking to work, shopping for pleasure etc.	
None	
Some but less than 1 hour	
1 hour but less than 3 hours	
3 hours or more	

10. Housework/Childcare	
None	
Some but less than 1 hour	
1 hour but less than 3 hours	
3 hours or more	

11. Gardening/DIY	
None	
Some but less than 1 hour	
1 hour but less than 3 hours	
3 hours or more	

12. Please state your walking pace	
Slow Pace	
Steady Average Pace	
Brisk Pace	
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: _____