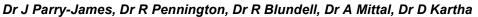
Hope Health Centre, Hawarden Road, Hope, Wrexham, Flintshire. LL12 9NP

Telephone: 01978 760468 www.wales.nhs.uk/hopefmc





NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

(NB all information supplied will be recorded in your confidential medical records)

Surname:		Forename(s):				
Date of Birth:	Marital stat	tus:				
Ethnicity:Gender						
Language preference English / Welsh (please delete as appropriate)						
vaccination reminders,	ntact via text message/email for to let you know that your preso ealthcare? *Yes/No (please de	cription or your sick note	s, invitations to health checks, is ready for collection and anything			
Yes/No (please delete	as appropriate)					
Email address:						
Please note, we may contact Smoking	t you to offer you support or advice if a	appropriate based on your sub	mission.			
Smoking status:	Never Smoked	Ex smoker	Current Smoker			
If current, how many:	Cigarettes per day	Ounces of tobacco p	er day Vape			
Alcohol How many units of alcohol do you drink a week?						
Please answer to the	e best of your knowledge:					
A 750ml bottle of wine contains 10 units A standard (175ml) glass of wine contains 2 units		A standard 70cl bottle of spirits contains 28 units A pint of 3.6% strength lager/beer/cider contains 2 units				
A single small shot of unit	f spirits (25ml) contains 1	A pint of 5.2% str units	A pint of 5.2% strength lager/beer/cider contains 3 units			
Height, Weight and	Blood pressure (BP mac	hine and scales in wa	iting room)			
Height:	Weight:	Ві	ood Pressure:			
Please note, we may contact	t you to offer you support or advice if a	ppropriate based on your sub	mission.			
Medication						
Are you on any repea	at medication? Yes/No					
	or email us your most recei questionnaire <i>(this allows u</i>		slip or evidence of your current eat for you).			
Allergies						
Do you have any alle	o you have any allergies? Yes/No If Yes, please give details:					
Drugs:						

NB: The following information you supply may assist us to provide good care for you whilst we wait for your previous medical records.

Family Histo	ory				
Is there any	of the following in	your family (family	ather, mother, brother, si	<i>ster)</i> before th	e age of 65?
Heart Diseas	e?	Yes / No	which family member?		
Stroke?		Yes / No	which family member?		
Cancer?		Yes / No	•		
Site of cance	r?				
Medical Hist	t orv - Please give	e details of any	/ current treatments/med	ical conditions	; ·
	.e.,				•
			•••••		
Carers					
	/have anyone wh	o looks after v	ou or your daily needs a	s Carer?	Yes/No
If Yes, would you like them to deal with your health affairs here?					Yes/No
	for anyone else?	•			Yes/No
(If Yes, pleas	se contact NEWC	IS about Care	rs support)		
Hausahaus					
Are you house				Yes/No	,
•		re unable to lea	ve their home at all, or if the		
•	-		sability, mental ill-health, or		
Military Vote	vran				
Military Vete	er served in the A	armed Forces?)	Yes/No)
riavo you ov		umou i oroco.		100/110	,
Communica	tion				
Do you have	any communicat	ion/informatio	n needs relating to senso	ory loss and, if	so, what are they and
how would yo	ou like us to com	municate with	you?		
Office use	only. (Please tick))			
NHS no:					
ID type			Address confirmation		
71					
Is this patien	t eligible for disper	sing services?	Yes / No		
Postcode dis	stance from practic	e:	miles		
Date form re	ceived:		Form ch	ecked by: (Initia	ıls)

Date inputted on EMIS: