***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 60Family Member: | **Yes/No** |
| History of Heart Disease over 60Family Member: | **Yes/No** |
| History of StrokeFamily 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.** |
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| **ADMINISTRATION USE ONLY** | **DATE** |
| Form Scanned: |  |
| Task sent to GP to review form and ask whether appointment required to be seen: |  |