**Patient Registration Questionnaire**

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| --- | --- |
| **Full Name:** |  |
| **Date of Birth:** |  |
| Q1) How satisfied are you with your current overall wellbeing? | Sad Face Icon Unhappy Face Symbol Stock Illustration - Download Image Now -  iStock 1 2 3 4 5  |
| Q2a) Do you smoke? | YES NO |
| Q2b) Have you ever smoked? | YES NO |
| Q2c) How many cigarettes do you smoke a day? | Less than 10 10 – 20 More than 20 |
| Q2d) Would you like help to stop smoking? | YES NO |
| Q3a) Do you drink alcohol? | YES NO |
| Q3b) If yes, how many units per week?* Pint of Beer = 2 units
* Glass of wine (175ml) = 2 units
* Single measure of spirit = 1 unit
 |  |
| Q4a) Do you any known allergies or sensitivities? | YES NO |
| Q4b) If **YES**, please give details: |  |
| Q5a) Do you have any disabilities? | YES NO |
| Q5b) If **YES**, please give details: |  |
| Q6) Is there any family history (parents/grandparents/siblings) of the following? *(Please circle)* | Asthma Diabetes Cancer StrokeHeart Disease |
| Q7) Are you taking any medication?If **YES**, please list: | YES NO |
| Q8) Do you suffer from any long-term conditions?If **YES**, please tick which below: | YES NO |

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| ANGINA | ARTHIRITIS | ASTHMA |
| CANCER | DIABETES | EPILEPSY |
| HIGH BLOOD PRESSURE | LEARNING DISABILITY  | OSTEOPOROSIS |
| MENTAL HEALTH CONDITION  | SKIN CONDITION | THYROID CONDITION |
| COPD | STROKE | DEMENTIA |
| PERIPHERAL VASCULAR DISEASE | HEART FAILURE | OTHER (PLEASE SPECIFY)……………………………. |