# One Medical GroupPatient Registration Questionnaire

**Patient Name:­­­­­­­­**

Q1) How satisfied are you with your current overall wellbeing?

 1 2 3 4 5



Q2) Do you have any long-term conditions?

Yes No

If Yes, please tick & answer following questions.

|  |  |  |
| --- | --- | --- |
| 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)……………………………. |

Q3) Do you take regular medications?

Yes No

If so, please list:

………………………………..

………………………………..

………………………………..

………………………………..

………………………………..

Q4) Are you able to attend the practice in person for appointments if necessary?

Yes No

Q5a) Do you smoke?

Yes No

Q5b) If yes, have been offered support to help stop smoking?

Yes No

Q6) How often do you have 6 or more drinks if female or 8 or more drinks if male?

(1 drink is ½ pint beer or 1 glass of wine or 1 single spirit)

Never

Monthly or less

2-4 times per month

2-3 times a week

4 or more times a week

Q7) How much time do you spend on physical exercise each week?

None

less than 1 hour

1-3 hours

> 3 hours

Q8) Please could you kindly record your height and weight below:

Height……………….

Weight………………

Q9) Do you have any additional communication needs? (i.e. visual or hearing impairments)

Yes No

If yes, can you tell us more………………………….

Q10) Do you identify as a carer?

Yes No

Q11) Do you consider yourself to have a learning disability?

Yes No

If yes, can you tell us more……………………………