Patient Registration Questionnaire

OneMedicalGroup
Improving Lives

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……