

Manylion y claf

Patient's details

Cwblhewch y rhan hon mewn PRIF LYTHRENNAU a thiciwch y blychau lle bo'n briodol
Please complete in BLOCK CAPITALS and tick as appropriate

Mr
 Mrs
 Miss
 Ms

Cyfenw
Surname

Dyddiad geni
Date of birth

Enwau cyntaf
Forenames

Rhif
GIG
NHS No.

Cyfenw(au) blaenorol
Previous surname/s

Adnabyddir fel
Known Name

Gwryw
Male Benyw
Female

Tref a gwlad eich geni
Town and country of birth

Enw'ch mam cyn priodi
Mothers Maiden Name

Cyfeiriad presennol
Current address

Cod Post
Postcode

Rhif ffôn
Telephone number

Helpwch ni i olrhain eich cofnodion meddygol blaenorol drwy ddarparu'r wybodaeth ganlynol

Please help us trace your previous medical records by providing the following information

Eich cyfeiriad blaenorol yn y DU, pan oeddech wedi'ch cofrestru gyda meddygfa meddyg teulu
Your previous address in the UK, whilst registered with a GP surgery

Enw'ch meddyg blaenorol pan oeddech yn y cyfeiriad hwnnw
Name of previous doctor while at that address

Cyfeiriad eich meddyg blaenorol
Address of previous doctor

Cod Post
Postcode

Os ydych o dramor

If you are from abroad

Eich cyfeiriad cyntaf yn y DU lle roeddech wedi cofrestru gyda meddyg teulu
Your first UK address where registered with a GP

Ydych chi erioed wedi cofrestru â Meddyg Teulu y GIG yn y DU?

Have you ever registered with a NHS GP in the UK?

Ydw
Yes

Nac Ydw
No

Os oeddech yn arfer byw yn y DU, dyddiad gadael
If previously resident in the UK, date of leaving

Y dyddiad y daethoch gyntaf i fyw yn y DU
Date you first came to live in UK

Ydych chi erioed wedi gwasanaethu fel aelod o luoedd arfog ei mawrhydi?

Have you ever served in HM Armed Forces?

Ydw
Yes

Nac Ydw
No

Os ydych yn dod yn ôl o'r Lluoedd Arfog

If you are returning from the Armed Forces

Cyfeiriad cyn ymrestru
Address before enlisting

Dyddiad ymrestru
Enlistment date

Dyddiad gadael
Discharge date

Rhif gwasanaeth neu bersonél, Rhif BFPO
Service or Personnel number, BFPO Number

Os oes angen i'ch meddyg weinyddu meddyginiaeth a theclynnau meddygol*

If you need your doctor to dispense medicines and appliances*

* Nid oes awdurdod gan bob meddyg i weinyddu meddyginiaeth
* Not all doctors are authorised to dispense medicines

Rwy'n byw mwy na milltir mewn llinell syth oddi wrth y fferyllydd agosaf
I live more than 1 mile in a straight line from the nearest chemist

Byddai'n anodd dros ben i mi gael gafael arnynt gan fferyllydd
I would have serious difficulty in getting them from a chemist

Eithrio o Gofnod Iechyd Unigol y GIG

Rwy'n dymuno eithrio o'r Cofnod Iechyd Unigol ac atal staff meddygol sy'n darparu gofal brys rhag gweld fy ngwybodaeth feddygol allweddol. Rwyf wedi derbyn digon o wybodaeth i wneud dewis gwybodus ac rwy'n cydnabod y gallai eithrio fel hyn amharu ar fy ngofal iechyd. Mae rhagor o wybodaeth ar gael yn www.wales.nhs.uk/cofnodiechydunigol neu drwy ffonio Galw Iechyd Cymru ar 0845 46 47

NHS Individual Health Record Opt Out

I want to opt out of the Individual Health Record and prevent emergency care medical staff being able to access my key medical information. I have received enough information to make an informed decision and I acknowledge that opting out could be detrimental to my healthcare. Further information is available by visiting www.wales.nhs.uk/individualhealthrecord or by calling NHS Direct on 0845 46 47

Ticiwch y blwch yma os hoffech chi dderbyn gohebiaeth oddi wrthym yn y Gymraeg
Please tick this box if you wish to receive correspondence from us in Welsh

Llofnod y claf
Signature of patient

Llofnod ar ran y claf
Signature on behalf of patient

Dyddiad
Date

Gweler trosodd ynghylch rhoi organau
Please see overleaf re: Organ donation

I'w gwblhau gan y meddyg

To be completed by the doctor

Enw'r Meddyg
Doctors Name

Cod HB
HB Code

Rwyf wedi derbyn y claf hwn ar gyfer gwasanaethau meddygol cyffredinol
I have accepted this patient for general medical services

Rwyf wedi derbyn y claf hwn ar gyfer gwasanaethau meddygol cyffredinol ar ran y meddyg isod sy'n aelod o'r feddygfa hon
I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Enw'r Meddyg, os yw'n wahanol i'r uchod
Doctors Name, if different from above

Cod HB
HB Code

Byddaf yn gweinyddu meddyginiaethau/teclynnau meddygol i'r claf hwn yn amodol ar Gymeradwyaeth yr Awdurdod Iechyd
I will dispense medicines/appliances to this patient subject to Health Board Approval

*Rwyf yn datgan bod yr wybodaeth hon, hyd y gwn i, yn gywir.
I declare to the best of my belief this information is correct.*

Llofnod Awdurdodedig

Authorised Signature

Enw
Name

Dyddiad _____ / _____ / _____
Date

Stamp y Feddygfa
Practice Stamp

MOUNT PLEASANT PRACTICE

Tempest Way, Chepstow, Monmouthshire NP16 5XR

Tel: 01291- 440154

Dr Annabelle Holtam Mr Hywel Jones

Dr Helen Beardsell Dr Aishwarya Kasha Dr Rachel Warrington

Dr Sian Donovan Dr Angharad Thomas Dr Katie Mellor

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

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

(Demographics Data set)

Surname: Forename(s):

NHS number (if known):

Date of Birth: Marital status:

Address:

..... Postcode:

Home tel: Mobile (if aged 16 and over):

Ethnicity:

Gender:

Language preference English / Welsh (*please delete as appropriate*)

Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, to let you know that your prescription or your sick note is ready for collection and anything else relevant to your healthcare?

***Yes/No (please delete as appropriate)**

We have an electronic method of contact available for patients to contact the surgery for non urgent requests – do you consent for us to correspond with you via this method and supply us with a preferred e-mail address for this purpose?

***Yes/No (please delete as appropriate)**

Email address:

Do you have a sensory loss that requires additional support

***Yes/No (please delete as appropriate)**

If Yes, please give details:

.....

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(Lifestyle data set)

Smoking

Do you smoke? Yes / No

If Yes, how many: Cigarettes per day Ounces of tobacco per day

Alcohol

For the following questions please answer to the best of your knowledge: We have provided a basic guide to alcohol content below to assist your completion:

A 750ml bottle of wine contains 10 units

A standard (175ml) glass of wine contains 2 units

A single small shot of spirits (25ml) contains 1 unit

A standard 70cl bottle of spirits contains 28 units

A pint of 3.6% strength lager/beer/cider contains 2 units

A pint of 5.2% strength lager/beer/cider contains 3 units

Follow the link below to access more information including a guide to calculating your alcohol intake - Alcohol units - NHS (www.nhs.uk)

Or you can use Alcohol Change's calculator - [Unit calculator | Alcohol Change UK](#)

How many units of alcohol do you drink a week?

Height and Weight

Please tell us your most recent measurements for the following (if known)

Height:

Weight:.....

Please note, we may contact you to offer you support or advice if appropriate based on your submission.

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(Medical data set)

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

Family History

Is there any of the following in your family (*father, mother, brother, sister*) before the age of 65?

Heart Disease? Yes / No which family member?

Stroke? Yes / No which family member?

Cancer? Yes / No which family member? Site

of cancer?

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug	Dosage

Please attach or forward us your most recent repeat medication slip if you have one.

Allergies

Do you have any allergies? Yes/No

If Yes, please give details:

.....

.....

Past Medical History

Please give details of any treatments/medical conditions:

.....

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(Additional needs/requirements data set)

Carers

Do you need/have anyone who looks after you or your daily needs as Carer? Yes/No

If Yes, would you like them to deal with your health affairs here? Yes/No

(A member of reception staff can help with these arrangements)

Do you care for anyone else? Yes/No

(If Yes, please ask the reception staff about Carers support)

Military Veteran

Have you ever served in the Armed Forces? Yes/No

Communication

Do you have any communication/information needs relating to sensory loss and, if so, what are they and how would you like us to communicate with you?

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.....
.....
.....

Thank you for completing this questionnaire.

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Acceptable Behaviour Contract

Patient Name	
Address	
NHS Number	

Responsibilities and Rights – A Patient Undertaking

Your Rights	Your Responsibilities
<i>Mount Pleasant Practice and their staff owe to you, as a patient, a duty of care and aim to provide services to meet your needs for healthcare and treatment.</i>	<i>You will not behave in any way, which can be considered to be violent, threatening, demanding or abusive.</i>
<i>Mount Pleasant Practice and their staff aim to provide health services that are sympathetic to your individual needs <u>within the resources which the ABUHB / Primary Care Independent Contractor has available.</u></i>	<i>You will treat Mount Pleasant Practice and their staff, fellow patients and their carers and visitors politely and with respect at all times. You will respect the fact that Mount Pleasant staff are obliged to provide health services to all patients, and you will not be unreasonably demanding as to adversely affect the care of other patients.</i>
<i>Mount Pleasant Practice and their staff are expected to treat you with courtesy and respect.</i>	<i>You will not consume alcohol or take any form of non-prescribed medication or drugs whilst on NHS premises.</i>
<i>Mount Pleasant Practice and their staff seek to deliver appropriate and effective healthcare and treatment to you.</i>	<i>You accept and understand that Mount Pleasant Practice is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. You accept and understand that no member of the Mount Pleasant Practice's team has to jeopardise their safety in providing you with care.</i>

***Violence** includes any incident where Mount Pleasant Practice and their staff, fellow patients and their carers are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, wellbeing or health of any member of ABUHB staff, Primary Care Independent Contractor, their staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threats of injury, abuse of alcohol or drugs, destruction of NHS property, threatening or intimidating behaviour as well as physical acts of violence. I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities as a patient, then this can result in the withdrawal of my rights as a patient of Mount Pleasant Practice and I can lose my right to receive mainstream NHS Primary Care Services.

Signature of patient	
Date	

