Practis Meddygol Uwchaled Medical Practice

HOLIADUR IECHYD CLEIFION NEWYDD

Cwblhewch yr holiadur er mwyn i ni gael braslun o'ch cefndir meddygol tra'r ydym yn aros i dderbyn eich cofnodion o'ch practis blaenorol.

Enw Llawn _____

MERCHED

Ydych yn feichiog? Ydw ☐ Nac ydw ☐

Ydych wedi cael prawf ceg y groth yn y 3 mlynedd diwethaf? Do ☐ Na ☐

Ydych wedi cael hysterectomi? Do ☐ Na ☐

Pa ddull atal genhedlu ydych yn ei ddefnyddio? _____

HANES MEDDYGOL

A ydych wedi dioddef o'r canlynol?

Alergedd	Do ☐	Na ☐	Asthma	Do ☐	Na ☐
Pwysedd gwaed uchel	Do ☐	Na ☐	Cancr	Do ☐	Na ☐
Problemau Iechyd Meddwl?	Do ☐	Na ☐	Clefyd y Siwgr	Do ☐	Na ☐
Epilepsi	Do ☐	Na ☐	Clefyd y Galon	Do ☐	Na ☐
Clefyd yr Arenau	Do ☐	Na ☐	Strôc	Do ☐	Na ☐

Rhowch fanylion unrhyw salwch, lawdriniaethau neu anafiadau;

HANES MEDDYGOL TEULUOL

A oes rhieni, brodyr neu chwiorydd wedi dioddef ô;

			Pwy?	Oedran	Manylion
Asthma?	Do ☐	Na ☐	_____	_____	_____
Pwysedd gwaed uchel?	Do ☐	Na ☐	_____	_____	_____
Cancr?	Do ☐	Na ☐	_____	_____	_____
Problemau Iechyd Meddwl?	Do ☐	Na ☐	_____	_____	_____
Clefyd y Siwgr?	Do ☐	Na ☐	_____	_____	_____
Epilepsi?	Do ☐	Na ☐	_____	_____	_____
Clefyd y Galon?	Do ☐	Na ☐	_____	_____	_____
Clefyd yr Arenau?	Do ☐	Na ☐	_____	_____	_____
Strôc?	Do ☐	Na ☐	_____	_____	_____

YSMYGU, ALCOHOL AC YMARFER CORFF

Erioed wedi ysmygu ☐ **Arfer ysmygu** ☐ **Yn ysmygu rwan** ☐

A hoffech dderbyn cymorth i roi'r gorau i ysmygu? Buaswn ☐ Na ☐

Sawl uned o alcohol a yfwch mewn wythnos arferol? Dim 1-5 5-10 10+

(1 uned = gwydr bach o win, ½ peint o gwrw, 1 mesur sengl o wirod)

Ydych yn gwneud ymarfer corff yn rheolaidd? Ydw ☐ Nac ydw ☐

Practis Meddygol Uwchaled Medical Practice

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete this form so that we have some basic medical information about you until we receive your records from your previous GP surgery.

Full Name _____

WOMEN

Are you pregnant? Yes ☐ No ☐

Have you had a cervical smear test in the last 3 years? Yes ☐ No ☐

Have you had a hysterectomy? Yes ☐ No ☐

Contraception method currently used _____

PERSONAL MEDICAL HISTORY

Have you ever suffered from;

Allergies	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
High Blood pressure?	Yes ☐	No ☐	Cancer?	Yes ☐	No ☐
Mental Health Problems?	Yes ☐	No ☐	Diabetes?	Yes ☐	No ☐
Epilepsy?	Yes ☐	No ☐	Heart Disease?	Yes ☐	No ☐
Kidney Disease?	Yes ☐	No ☐	Stroke?	Yes ☐	No ☐

Please give details of any major illnesses, operations or injuries you've had;

FAMILY MEDICAL HISTORY

Have any of your parents, brothers or sisters ever suffered from;

		Who?	Age	Details
Asthma?	Yes ☐ No ☐	_____	_____	_____
High Blood pressure?	Yes ☐ No ☐	_____	_____	_____
Cancer?	Yes ☐ No ☐	_____	_____	_____
Mental Health Problems?	Yes ☐ No ☐	_____	_____	_____
Diabetes?	Yes ☐ No ☐	_____	_____	_____
Epilepsy?	Yes ☐ No ☐	_____	_____	_____
Heart Disease?	Yes ☐ No ☐	_____	_____	_____
Kidney Disease?	Yes ☐ No ☐	_____	_____	_____
Stroke?	Yes ☐ No ☐	_____	_____	_____

SMOKING, ALCOHOL AND EXERCISE

Never Smoked ☐ **Ex-Smoker** ☐ **Current Smoker** ☐

Would you be interested in our smoking cessation service to help you stop? Yes ☐ No ☐

How many units of alcohol do you drink in a typical week? **None** **1-5** **5-10** **10+**

(1 unit = small glass of wine, ½ pint of beer, 1 single pub spirit measure)

Do you exercise regularly? Yes ☐ No ☐