NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:
To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor/nurse to make an initial assessment of your health which will help in your future treatment. [Note: could you please make an appointment for your new patient health check]

Surname: …….. Forename(s): ……

Date of Birth: …….. Marital status: ….……

Address:
…….

……..…

Postcode: ……..….

Home tel: ……..……

Mobile: ……..…

Email address:
……

Occupation:
…….

Weight (approx): …….. Height: ……

Date of completion of this form: …….

SMOKING

Do you smoke? Yes / No

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

How old were you when you started smoking? ……..

EX-SMOKERS

How old were you when you stopped smoking? ……
How much did you smoke per day? ……..

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

DIET

Do you add salt to your food after cooking? Yes / No

Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No

Has your Cholesterol been checked in the last 2 years? Yes / No

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise? ……
How many times per week? ……..

FAMILY HISTORY

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

Heart Disease (heart attacks, angina) 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: …….

Name of drug: ……..
Dosage: …….

Name of drug: ……..
Dosage: …….

ALLERGIES

Are you allergic to any substances or foods? Yes / No

If yes, please give details:
……

……

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

……

Please give details of any treatment for any chronic medical conditions:

……

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

……

IMMUNISATIONS

Dates of Triple/polio/HIB:

……..

Dates of MMR:

……...……..

Date of last Tetanus:

…….

FEMALE PATIENTS

Date of most recent cervical smear: ……..

Result of most recent smear: …….

Please give details of any complications in pregnancy:

……

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
(the receptionist can help with these arrangements)

Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

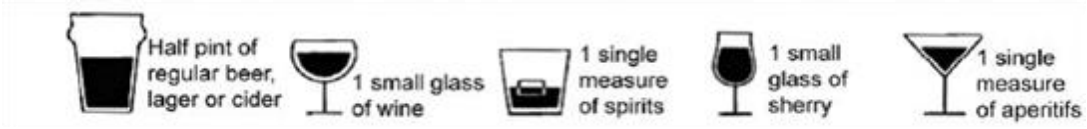
Ethnicity: (Please circle)

British	Black African	Pakistani
Mixed British	Black other	Bangladeshi
Black, other mixed	Chinese	Black Caribbean
Indian	Other non mixed	

Thank you for completing this questionnaire. Our healthcare assistant will assess the information provided and will discuss your health and general check with you at your new patient assessment.

Audit C- Alcohol Questionnaire

This is one unit of alcohol



Each of these is more than one unit

Questions	Scoring System					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	**Never**	**Monthly or less**	**2-4 times per month**	**2-3 times per week**	**4+ times per week**	
How many units of alcohol do you drink on a typical day when you are drinking?	**1-2**	**3-4**	**5-6**	**7-9**	**10+**	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or Almost Daily**	

Score ☐

Scoring:

A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive

If you have scored 5 or above, please turn over & complete remaining questions

Remaining AUDIT questions

Questions	Scoring System					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	**Never**	**Less than Monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you had a feeling of guilt or remorse after drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	**Never**	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**	
Have you or somebody else been injured as a result of your drinking?	**No**		**Yes, but not in the last year**		**Yes, during the last year**	
Has a relative or friend, doctor of other health worker been concerned about your drinking or suggested that you cut down?	**No**		**Yes, but not in the last year**		**Yes, during the last year**	

Scoring: 0-7 Lower Risk, 8-15 Increasing risk, 16-19 Higher Risk, 20+ possible dependence

TOTAL Score equals Audit C Score (Previous Page) + Score of remaining questions

Total - ☐