

NEW PATIENT QUESTIONNAIRE (FOR PATIENTS AGED 15 AND OVER) WRITE TODAY'S DATE HERE:

PHONE NUMBER: MOBILE PHONE NUMBER:.....
 E-MAIL ADDRESS:TITLE: MR/ MRS/MISS/MS/OTHER.....
 FAMILY NAME: FORENAME(S)
 CURRENT ADDRESS:
 POST CODE: **DATE OF BIRTH**
 PREVIOUS ADDRESS:.....(INCLUDING POSTCODE).....
 TOWN/COUNTRY OF BIRTH:OCCUPATION.....
 HAVE YOU RECENTLY MOVED TO THIS COUNTRY? YES / NO? IF YES, WHEN?

CONTACT IN CASE OF EMERGENCY:

NAME:.....CONTACT NUMBER:.....
 RELATIONSHIP TO PATIENT:.....

IF YOUR NAME OR ADDRESS CHANGE IN THE FUTURE - PLEASE LET US KNOW AS SOON AS POSSIBLE. NOT DOING SO CAN RESULT IN DEDUCTION FROM THE PATIENT REGISTER.

ETHNIC GROUPS (census) Is your first language ENGLISH Yes / No if No, what language do you speak?					
White <input type="checkbox"/>	<hr style="width: 20%; margin-left: 10px;"/>		Black - African <input type="checkbox"/>	Black, other, non-mixed origin <input type="checkbox"/>	
Black, other -mixed <input type="checkbox"/>	Other black ethnic group <input type="checkbox"/>		Other Asian ethnic group <input type="checkbox"/>		
Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Chinese <input type="checkbox"/>	Other ethnic mixed origin <input type="checkbox"/>	
Vietnamese <input type="checkbox"/>			Other ethnic group <input type="checkbox"/>	Ethnic group not given - refused <input type="checkbox"/>	

ALCOHOL: Please complete the questions below. **Recommended weekly intake: Women - up to 14 units
 Men - up to 21 units (e.g. 175ml glass of wine = 2 units; pint of beer/lager/cider = 2 units, single measure of spirit = 1 unit
 How many units do you drink per week?**

QUESTIONS	SCORING SYSTEM					YOUR SCORE
	0	1	2	3	4	
How often do you have a drink that contains alcohol	NEVER	MONTHLY OR LESS	2 - 4 TIMES PER MONTH	2 - 3 TIMES PER WEEK	4+ TIMES PER WEEK	
How many standard alcoholic drinks do you have on a typical day when you are drinking	1 - 2	3 - 4	5 - 6	7 - 8	10 +	
How often do you have 6 or more standard drinks on one occasion?	NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY	

Because alcohol use can affect your health and can interfere with certain medication and treatments it is important that we ask some questions about your use of alcohol. Your answers are confidential so please be honest. If you have scored a total of 5+ above, this indicates increasing or higher risk drinking. If your score is 5+ above please answer the questions over the page and enter your score. If you would like help to reduce the amount of alcohol you drink please indicate this over the page.

Do you currently **SMOKE** YES/NO **HOW MANY CIGARETTES DO YOU SMOKE PER DAY?**

Are you an **EX-SMOKER?** YES/ NO in what year did you stop?

Smoking can cause a large number of serious health problems and we recommend all smokers should try to stop.

Meanwood Group Practice can help you to stop smoking – There are various “Quit Smoking” services available at the surgery and locally.

If you would like help with stopping smoking and would like further information please indicate by ticking the box

I WOULD LIKE HELP WITH STOPPING SMOKING

ALLERGIES:

Are you allergic to PENICILLIN? YES / NO

Are you allergic to any other MEDICINE YES / NO If “YES”, please give the

Name of medicine:.....

FAMILY HISTORY: Please indicate which of these family members have now, or have had in the past the following: M = mother; F = father; S = sister; B = brother; C = child

Please tick the box and indicate by the letter which member of your family this applies to:

- a) Glaucoma
- b) Stroke
- c) Heart attack (younger than 60)
- d) Died before age 60
- e) Diabetes
- f) Cancer

FEMALE PATIENTS:

Have you ever given birth to children? YES / NO If YES, How Many

Have you ever had a miscarriage? YES / NO If YES, How Many.....

Have you ever had a **CERVICAL SMEAR** YES / NO / DON'T KNOW, If YES, when.....
(If you are aged between 25 – 64 we will invite you for a routine cervical smear every four/five years. If you **do not wish** to be invited for a cervical smear within the next three years, please sign below)

What is your:

HEIGHT:**WEIGHT:**.....

BLOOD PRESSURE:/..... (There is a blood pressure machine in the waiting room – should you require any help in using the machine please let the receptionist know.)

SCREENING TEST: If you are aged between 15 and 24 we would like to offer you a **FREE** test for **CHLAMYDIA** – this is a simple test which you can carry out yourself, no need for an appointment with the doctor or nurse. If you would like to have a test please ask the receptionist for a kit.

We have a 24 hour turnover for patient registration after which time you are free to make appointments with the doctor or nurse at your convenience. You may also register for our “on-line” service – please ask at reception.

Score from AUDIT- C (other side)



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 or 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

If you would like to be referred for help to reduce your drinking please

Tick Here:

