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Coggeshall Surgery, Stoneham Street, Coggeshall, Colchester. CO6 1UH

NEW PATIENT QUESTIONNAIRE

TITLE	YOUR SURNAME	YOUR FIRST NAME(S)
Mr/Miss/Ms/Mrs/Dr		
Telephone Contact Numbers	Home:	Mobile:
	Work:	
Address		
Postcode		**Date Of Birth**

ETHNIC ORIGIN - *Please refer to attached sheet and circle the appropriate letter*
A B C D E F H J K L M N P R S

FAMILY HISTORY *Tick to indicate if any member of your family has suffered from any of the following medical problems*		Yes	No	Relationship to You
Stroke				
Angina				
High Blood Pressure				
Heart Attack				
High blood Cholesterol				
Diabetes				
Asthma/COPD				
Cancer - What kind?				

SIGNIFICANT OPERATIONS/ILLNESSES/STAY IN HOSPITAL *State any operations, significant illnesses or hospital stays **YOU** have had*	
Date	**Details**

MEDICAL PROBLEMS Do **YOU** suffer from any of the following? Tick as appropriate and give details			Yes	No	Date of Onset	Medication/ Treatment
Stroke						
Angina						
High Blood Pressure						
Heart Attack						
High blood cholesterol						
Diabetes						
Asthma/COPD						
Cancer	If yes, what kind?					

LIFESTYLE - *Tick appropriate box and fill in relevant spaces*		
Smoking Status		
Never Smoked □		
Passive Smoker □		
Ex- Smoker □	Number of cigarettes/cigars* per day	
	Weight of tobacco per day	
	Date Ceased	
Smoker □	Number of cigarettes/cigars* per day	
	Weight of tobacco per day	
	Date Started	

Alcohol Consumption		
Teetotaller □		
Consume alcohol □ ***if you tick this box please complete the additional questionnaire at page 3.***	Number of units per week	

Exercise
Impossible □ Avoid Exercise □ Enjoy Light exercise □ Enjoy Moderate Exercise □ Enjoy Heavy Exercise □

IMMUNISATION HISTORY *List all your known routine and travel immunisations*	
Date	**Immunisation/Travel Vaccination**

CARERS	Yes	No	Details
Do you have a carer?			
If yes, who is your carer?			
Are you a carer?			
If yes, who do you care for?			
Do you have a living will?			
Are you registered disabled?			
Are you registered blind?			

SIGNATURE	**PRINT NAME**	**DATE**

FOR FEMALE PATIENTS ONLY					
	Yes	No	Details		
Have you had any pregnancies?			Number of pregnancies		Dates:
Contraception/HRT Please name your tablet, implant or IUD			Name of Contraceptive		Name of HRT
If you are aged 18-65, please give details of your last smear test	Where smear taken			When	
If known, give result					

ALCOHOL QUESTIONNAIRE 1 - TO BE COMPLETED AS PART OF YOUR MEDICAL REGISTRATION

GUIDE TO ALCOHOL UNITS	Pint of regular beer/lager/cider = 2 units	Alcopop or can of lager = 1.5 units	Glass of wine (175ml) = 2 units	Single measure of spirits = 1 unit	Bottle of wine = 9 units

NAME: **DATE OF BIRTH**:

Do you ever drink alcohol? *(please tick answer on right)*	❑ **No** – you do not need to answer the questions below ❑ **Yes** – please complete the questions below

Questions	PLEASE CIRCLE YOUR ANSWERS BELOW AND THEN CALCULATE AND ENTER YOUR SCORE ON THE RIGHT					YOUR SCORE
	0	1	2	3	4	
How often do you have: 8 drinks (men) or 6 drinks (women) in one day?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
Only answer the following questions if your answer above is 2 (monthly) or more						
How often in the last year have you not been able to remember what happened when drinking the night before?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often in the last year have you failed to do what was expected of you because of drinking?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	*No*		*Yes, but not in the last year*		*Yes, during the last year*	
					YOUR TOTAL SCORE*	

***Men** if you score 5 or more, please complete the second questionnaire overleaf

***Women** if you score 4 or more, please complete the second questionnaire overleaf

ALCOHOL QUESTIONNAIRE 2 - TO BE COMPLETED AS PART OF YOUR MEDICAL REGISTRATION

NAME:	**DATE OF BIRTH:**

Additional questions	**PLEASE CIRCLE YOUR ANSWERS BELOW AND THEN CALCULATE AND ENTER YOUR SCORE ON THE RIGHT**					**YOUR SCORE**
	0	**1**	**2**	**3**	**4**	
How often in the past year have you found you were not able to stop drinking once you had started?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often in the past year have you failed to do what was expected of you because of alcohol?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often in the past year have you needed an alcoholic drink in the morning to get you going?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often in the past year have you had a feeling of guilt or regret after drinking?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
How often in the past year have you not been able to remember what happened when drinking the night before?	*Never*	*Less than monthly*	*Monthly*	*Weekly*	*Daily or almost daily*	
Have you or someone else been injured as a result of drinking?	*No*	-	*Yes, but not in the last year*	-	*Yes, during the last year*	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	*No*	-	*Yes, but not in the last year*	-	*Yes, during the last year*	
					YOUR TOTAL SCORE	

YOUR NAME: ………..…………………………………………..

YOUR DATE OF BIRTH: ………………..……

Please attach your repeat slip (if any) to this sheet, or give details here:

Name of Medication	Strength	Dose	Quantity	Reason for Taking