

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

FIRST LANGUAGE

FAMILY HISTORY <i>Tick to indicate if any member of your family has suffered from any of the following medical problems</i>	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			Yes	No	Date of Onset	Medication/ Treatment
Do YOU suffer from any of the following? Tick as appropriate and give details						
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 <input type="checkbox"/>			
Passive Smoker <input type="checkbox"/>			
Ex- Smoker <input type="checkbox"/>	Number of cigarettes/cigars* per day		
	Weight of tobacco per day		
	Date Ceased		
Smoker <input type="checkbox"/>	Number of cigarettes/cigars* per day		
	Weight of tobacco per day		
	Date Started		
Alcohol Consumption			
Teetotaller <input type="checkbox"/>			
Consume alcohol <input type="checkbox"/> if you tick this box please complete the additional questionnaire at page 3.		Number of units per week	
Exercise			
Impossible <input type="checkbox"/> Avoid Exercise <input type="checkbox"/> Enjoy Light exercise <input type="checkbox"/> Enjoy Moderate Exercise <input type="checkbox"/> Enjoy Heavy Exercise <input type="checkbox"/>			






IMMUNISATION HISTORY	
<i>List all your known routine and travel immunisations</i>	
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
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NAME:	DATE OF BIRTH:
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Do you ever drink alcohol? (please tick answer on right)	<input type="checkbox"/> No – you do not need to answer the questions below <input type="checkbox"/> Yes – please complete the questions below
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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?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
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?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
How often in the last year have you failed to do what was expected of you because of drinking?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	<i>No</i>		<i>Yes, but not in the last year</i>		<i>Yes, during the last year</i>	
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?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
How often in the past year have you failed to do what was expected of you because of alcohol?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
How often in the past year have you needed an alcoholic drink in the morning to get you going?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
How often in the past year have you had a feeling of guilt or regret after drinking?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
How often in the past year have you not been able to remember what happened when drinking the night before?	<i>Never</i>	<i>Less than monthly</i>	<i>Monthly</i>	<i>Weekly</i>	<i>Daily or almost daily</i>	
Have you or someone else been injured as a result of drinking?	<i>No</i>	-	<i>Yes, but not in the last year</i>	-	<i>Yes, during the last year</i>	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	<i>No</i>	-	<i>Yes, but not in the last year</i>	-	<i>Yes, during the last year</i>	
YOUR TOTAL SCORE						

