New Patient Questionnaire- Adult

The practice has a web based patient participation group, if you would like to participate please check our website for information and updates.

Personal Details

Surname:			
Forename(s):			
Date of Birth:			
Address:			
Post Code:		Telephone No.	
Mobile No:		Occupation:	

Do you consent to us contacting you via SMS text? Yes □ No □	
Do you consent to us contacting you via email? Yes □ No □	Email:
Are you housebound? (Please tick) Yes □ No □	Are you a carer? Yes □ No □ *see below
Are you a Military Veteran? Yes □ No □	Are you cared for? Yes □ No □

Do you have any specific disabilities or access needs; we need to be aware of?

Do you have any communication requirements? E.g. Hearing loop. If so, please state:

Ethnicity & Language

The Government has requested that we record the ethnicity and first language of all of our patients. Please tick the category which best describes you:

White British □	Mixed British □	Other Black Background □	White and Asian □
White British and Black Caribbean □	Chinese □	Other mixed Background □	Other Asian Background □
White and Black African □	Caribbean □	Pakistani or British Pakistani □	
Other White Background □	African □	Indian or British Indian □	

Other ethnicity not listed above:	
What is your first language?	
If not English, do you require a translator?	

Family History (Parents, brothers, sisters or children)

Asthma	Stroke	Bowel Cancer	Breast Cancer
Diabetes	Heart trouble	High Cholesterol	

Other inherited disease (please state):	

*This is to enable us to support you as a Carer. For example inviting you in for immunisations which you would not receive if we did not know you were a Carer. It is not about whether you receive Carers Benefits or not.

ADULT

Illness, Drugs and Treatment

Please nominate a pharmacy, for prescriptions to be sent to ……………………………………………

If you are on repeat medication please attach a copy of your repeat prescription slip. This is available from your pharmacy or previous GP Surgery.

Please give details of any important illnesses or operations you have had. Please include any dates.

Do you have any allergies? Yes ☐ No ☐

If Yes, please tell us about your allergy/allergies:

Lifestyle

How much do you weigh?		What is your height?	

EXERCISE - Please tick which category best describes you:

Avoid exercise ☐	Aerobic exercise twice a week ☐
Aerobic exercise once a week ☐	Aerobic exercise more than 3 times per week ☐

Light exercise (no noticeable change in breathing pattern) ☐

SMOKING	Do you smoke? If Yes, how many per day? ………………..
	Have you ever smoked? Yes ☐ No ☐ Date ceased smoking approx …………..
	Do you use an E-Cigarette? Yes ☐ No ☐

Please complete the attached questionnaire regarding your alcohol consumption. We have provided some information below for your reference.

This is one unit of alcohol…

Half pint of "regular" beer, lager or cider

Half a small glass of wine

1 single measure of spirits

1 small glass of sherry

1 single measure of aperitifs

…and each of these is more than one unit

Pint of "regular" beer, lager or cider

Pint of "strong" or "premium" beer, lager or cider

Alcopop or a 275ml bottle of regular lager

440ml can of "regular" lager or cider

440ml can of "super strength" lager

250ml glass of wine

75cl Bottle of wine (12%)

ADULT

AUDIT–C

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?	0 - 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	

Remaining AUDIT question

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