

# NEW PATIENT QUESTIONNAIRE

## Confidential

### Welcome to Patford House Surgery

Please help us by filling in this questionnaire as fully and accurately as you can as it may take some time for your previous medical records to reach us. This information will help us to provide you with the best possible medical care. A specimen of urine is required which should be brought in with your registration form.

#### PERSONAL DETAILS

**Title** (Mr/Mrs/Miss/Ms/Dr/Other): .....

**First Name:** .....

**Surname:** .....

**Date of Birth:** .....

**Address:** .....

.....

**Telephone number(s):** ..... **Mobile:** .....

**E-mail address:** .....

**Marital Status:** ..... **Height:** ..... **Weight:** .....

**Which ethnic origin do you belong to?** Please tick one

White  Black or Black British  Asian or Asian British  Mixed

Chinese  Other

**First Language:** .....

**Occupation** (please give previous occupation if retired): .....

**Do you care for a chronically sick or disabled friend/relative?** Yes  No

**Do you live alone?** Yes  No

**Next of Kin name:** .....

**Relationship to you:** .....

**Next of Kin contact details:** .....

.....

#### PAST HEALTH

**Do any of the following apply to you? Please tick as appropriate.**

	Yes, currently	Yes, in the past	No, never
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/duodenal /peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any other significant health problems?

.....  
Have you had any operations?

.....  
Has anyone in your family had any of the following? Please tick as appropriate.  
If yes, please state which family member this applies to.

	YES	NO	If yes, were they under 65?
Heart disease	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/duodenal /peptic ulcer	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>
Mental health problems	<input type="checkbox"/> .....	<input type="checkbox"/>	<input type="checkbox"/>

### LIFESTYLE

#### Smoking:

Do you smoke? Yes  No  If yes, how many do you smoke per day? .....

Are these Cigarettes  Cigars  Roll your own  Pipe  (please tick any that apply)

If no, have you ever smoked? Yes  No  When did you give up? .....

Smoking is detrimental to your health. If you would like support to give up, please make an appointment with one of our practice nurses.

#### Alcohol Consumption:

How many units do you drink in an average week? .....

Is this: Beer  Wine  Spirits

#### Exercise:

Do you undertake regular sport or exercise? Yes  No

If yes, please give details: .....

### MEDICATION

Please list below any medication you take regularly:

Medication	Strength	How often

Are there any medications that upset you? .....

Do you have any allergies? .....

## ALCOHOL CONSUMPTION

The NHS has requested that we record more in-depth information regarding our patient's alcohol consumption. We would be grateful if you could please take a few minutes to answer the questions below and return to us with your registration forms. Thank you.

How often do you have a drink containing alcohol?

Never (0)      Monthly or less (1)      2-4 times per month (2)  
2-3 times per week (3)      4 or more per week (4)

How many standard drinks containing alcohol do you have on a typical day when drinking?

1 or 2 (0)      3 or 4 (1)      5 or 6 (2)      7 to 9 (3)      10 or more (4)

How often do you have six or more drinks on one occasion?

never (0)      less than monthly (1)      monthly (2)      weekly (3)  
daily or almost daily (4)

During the past year, how often have you found that you were not able to stop drinking once you had started?

never (0)      less than monthly (1)      monthly (2)      weekly (3)  
daily or almost daily (4)

During the past year, how often have you failed to do what was normally expected of you because of drinking?

never (0)      less than monthly (1)      monthly (2)      weekly (3)  
daily or almost daily (4)

During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

never (0)      less than monthly (1)      monthly (2)      weekly (3)  
daily or almost daily (4)

During the past year, how often have you had a feeling of guilt or remorse after drinking?

never (0)      less than monthly (1)      monthly (2)      weekly (3)  
daily or almost daily (4)

During the past year, have you been unable to remember what happened the night before because you had been drinking?

never (0)      less than monthly (1)      monthly (2)      weekly (3)  
daily or almost daily (4)

Have you or someone else been injured as a result of your drinking?

no (0)  
Yes, but not in the past year (2)  
Yes, during the past year (4)

Has a relative or friend, Doctor or other health worker been concerned about your drinking or suggested you cut down?

no (0)  
yes, but not in the past year (2)  
yes, during the past year (4)

### **SCORING**

8 or under - normal alcohol consumption

9 and above - please make an appointment to see the Practice Nurse

**THANK YOU FOR COMPLETING THIS FORM**  
**Please return this form to Patford House Surgery Reception**