

New Patient Questionnaire

Welcome to **The Practice**. It may take several weeks for your records to reach us from your previous doctor. Answering these questions will help us to provide good medical care for you during this time. The information is confidential.

If you are transferring directly from another GP surgery in the UK then you may register by post. If not then you will need to register at the surgery in person and bring some ID with you.

APPLICANT DETAILS

Title: Mr/Mrs/Miss/Ms/Other.....
 Name.....
 Address.....

 Postcode.....
 Occupation/School.....
 Tel. N° (Home).....
 Work/School N°.....
 Mobile.....
 Date of Birth.....
 E-mail.....

PARENT/GUARDIAN DETAILS (if under 16)

Title: Mr/Mrs/Miss/Ms/Other.....
 Name.....
 Address.....

 Postcode.....
 Occupation.....
 Tel. N° (Home).....
 Work N°.....
 Mobile.....
 Date of Birth.....
 E-mail.....

MALE/FEMALE **WEIGHT** **HEIGHT**

MEDICAL HISTORY

Please indicate whether you have had any of the following:

High Blood Pressure Asthma Epilepsy Mental Illness/Depression
 Heart Disease Stroke Diabetes

Please give details of any other significant illness or surgical operation:

.....

.....

Please give date and result of last smear.....

MEDICATION/DRUGS

Please list ALL medication you take (including the contraceptive pill) and any over the counter purchases from the chemist

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ALLERGIES

Please give details of any known allergies (medicines, food, insect bites)

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ETHNICITY

The Department of Health asks us to monitor the ethnicity of our patients. Please tick one of the descriptions below:

White – British	<input type="checkbox"/>	Mixed – Asian/White	<input type="checkbox"/>	Indian	<input type="checkbox"/>
White – Irish	<input type="checkbox"/>	Mixed – any other	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
White – other white	<input type="checkbox"/>	Black – African	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Mixed – Black Caribbean/White	<input type="checkbox"/>	Black – Caribbean	<input type="checkbox"/>	Asian – other	<input type="checkbox"/>
Mixed – Black African/White	<input type="checkbox"/>	Black – other	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Any other ethnic group	<input type="checkbox"/>	I do not wish to answer this question			<input type="checkbox"/>

First Language.....

FAMILY HISTORY Please indicate below whether or not any of your immediate family have ever suffered from any of the following and if yes, who:

If 'Yes' please indicate family member & age diagnosed

High Blood Pressure

Epilepsy

Mental Illness

Diabetes

Asthma

Stroke

Heart Disease

Cancer (specify)

Any other significant inherited problems

.....

.....

NEXT OF KIN

Name..... Relationship.....

Contact numbers: Home..... Mobile.....

Address.....

.....

SMOKING Please indicate whether you have ever smoked (Over 15 only)

Currently Smoke Ex-smoker Never Smoked

If you have given up smoking, when did you do so?

ALCOHOL CONSUMPTION (1 pint beer = 2 units, 1 small glass of wine = 1 unit, 1 single short = 1 unit)

How many units of alcohol do you drink in an average week..... Never drink alcohol

CARER STATUS Are you caring for someone or does someone care for you?

A Carer is a person who is looking after, or is responsible for, the care of a relative, friend or neighbour whose health is impaired by old age, or who is mentally or physically disabled.

My Carer is:

Name.....

Address.....

.....

.....

Postcode.....

Tel. No (Home).....

Relationship to me.....

I care for:

Name.....

Address.....

.....

.....

Postcode.....

Tel. No (Home).....

Relationship to me.....

DISABILITY Do you consider yourself to have a disability? No/Mild/Moderate/Severe (delete as appropriate). Please supply details below:

.....

.....

Where did you hear about The Practice?

Friend / Relative School Estate Agent Advert

Local Knowledge Website Mail Leaflet / Flyer

Other (please specify).....

Was there anything in particular that attracted you to registering with The Practice?

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Thank you for answering this questionnaire. It will greatly help us to look after you and your family.

Please fill in the following DOH questionnaire:

Name:

Date of Birth:

Male/Female

FAST ALCOHOL SCREENING TEST [FAST]

Questions	Scoring system					Your score
	0	1	2	3	4	
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	
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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:

- A score of 0 on the first question indicates FAST negative, you do not need to answer any more questions.
- A total of 1 – 2 on the first question then continue with the next three questions.
- A total of 3 – 4 on the first question, this is a positive screen, go straight onto the AUDIT questions overleaf
- An overall total score of 3 or above is FAST positive. Go onto ask AUDIT overleaf.



A pint of regular beer, lager or cider



A pint of "strong"/ "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 (12%)



Bottle of wine [12.5%]

Name:

Date of Birth:

Male/Female

Score from FAST (other side)



Remaining AUDIT questions

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?	1 - 2	3 - 4	5 - 6	7 - 8	10+	
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 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	
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	

Scoring:

0 – 7 Lower risk

8 – 15 Increasing risk

16 – 19 Higher risk

20+ Possible dependence

