New Patient Registration/Health Questionnaire

Dear Patient, To register with the Practice please complete this questionnaire fully. The information will help the doctor to make an initial assessment of our health which will help in your future treatment.

Date of completion of this form:……..

Full Name…….Date of Birth…….

Email Address……..

Mobile Telephone No…….. Home Telephone Number……..

Please use the equipment in our waiting room to provide us with the following information:
Weight……. Height…….Blood Pressure…….Pulse……..

What is your ethnic group? **What is your first language?**

Smoking: Do you smoke? **YES/NO** How old were you when you started smoking?.....

If YES, how many Cigarettes per day…….Cigars per day……Ounces of tobacco per day……

Ex-Smoker
How old were you when you stopped?.....How many did you smoke per day?.....

Family History - Is there any of the following in your family (father, mother, brother, sister) before age of 65? Heart Disease (heart attacks, angina) YES/NO Which family member?.....
Stroke? YES/NO Which family member?.....
Cancer? YES/NO Which family member?.....
Site of cancer?.....

Female Patients Only who currently use contraception
Please indicate if you use the following form of contraception
Implant Y/N Date Fitted Coil Y/N Date Fitted

Emergency Contact Person
Name……..Relationship……
Contact Telephone No……..
Address……..

Carers
Do you need/have anyone who looks after you or your daily needs as a carer? YES/NO

If YES would you like them to deal with your health affairs here? YES/NO
(the receptionist can help with these arrangements)

Do you care for anyone else? YES/NO
If YES ask the receptionist about Carers support

Communication With Patients
We are looking to improve how we communicate with patients. Please tell us if you need information in a different format or need communication support.

Alcohol - 1 unit = ½ pint of beer, 1 small glass of wine or 1 single spirit.

1. How often do you have a drink containing alcohol? 0 – Never 1 - Monthly or less
2 - 2 to 4 times a MONTH 3 - 2 to 3 times a WEEK 4 - 4 or more times a week

If you replied never to Question 1, please skip Questions 2 -8 and answer only Questions 9 and 10

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
0 - 1 or 2 drinks 1 - 3 or 4 drinks 2 - 5 or 6 drinks 3 - 7 or 8 or 9 drinks 4 - 10 or more drinks

3. How often do you have six or more drinks on one occasion?
0 - Never 1 - Less than monthly 2 – Monthly 3 – Weekly 4 - Daily or almost daily

If you scored 0 points to Questions 2 and 3, please skip Questions 4 -8 and answer only Questions 9 and 10. Otherwise continue with all Questions.

4. How often during the last year have you found that you were not able to stop drinking once you had started?
0 – Never 1 - Less than monthly 2 – Monthly 3 – Weekly 4 - Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
0 - Never 1 - Less than monthly 2 - Monthly 3 – Weekly 4 - Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
0 - Never 1 - Less than monthly 2 – Monthly 3 - Weekly 4 - Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
0 - Never 1 - Less than monthly 2 - Monthly 3 – Weekly 4 - Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
0 - No, never 2 - Yes, but not in the last year 4 - Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
0 - No, never 2 - Yes, but not in the last year 4 - Yes, during the last year

Scores of 8 or more are considered an indicator of hazardous and harmful alcohol use. If your score is higher than 8 we will contact you to discuss this with you further

Please note this practice is signed up to Summary Care Records sharing, this will allow hospitals and other health care professionals to access your records and obtain a history of medication you take and also any allergies that you might have. Your information will be automatically be added to the sharing of information unless you circle the **X**

Please hand completed forms into Reception