

Alrewas Surgery

New Patient Questionnaire

Please complete as much information as possible and hand this form back to Reception with your other registration documents.

ALL INFORMATION GIVEN IS HELD IN COMPLETE CONFIDENCE

PERSONAL DETAILS

1

Title (Mr, Mrs, Ms, Miss, Master, Dr, etc) _____ **Date of Birth** _____

Forename(s) _____ **Surname** _____

Preferred name _____

Full Address _____

_____ **Postcode** _____

Telephone Numbers Home _____ Work _____

Mobile _____

Do you agree to receiving text messages for appointment reminders and other general health information? **YES / NO**

1a

E-mail address _____

Marital Status (Single, Married, Divorced, Widowed, etc) _____

Occupation _____

Children? YES NO

Name(s) and date(s) of birth of child(ren) _____

ETHNICITY

1

We have been requested by South Staffordshire Primary Care Trust to record Ethnic Origin. Please tick the appropriate option. If you choose not to answer please tick this box Thank you.

- | | | |
|------------------------|--|---|
| White | <input type="checkbox"/> British
<input type="checkbox"/> Irish | <input type="checkbox"/> Other White background |
| Mixed | <input type="checkbox"/> White and Black Caribbean
<input type="checkbox"/> White and Black African | <input type="checkbox"/> White and Asian
<input type="checkbox"/> Other Mixed background |
| Asian or Asian British | <input type="checkbox"/> Indian
<input type="checkbox"/> Pakistani | <input type="checkbox"/> Bangladeshi
<input type="checkbox"/> Other Asian background |
| Black or Black British | <input type="checkbox"/> Black Caribbean
<input type="checkbox"/> Black African | <input type="checkbox"/> Other Black background |
| Other Ethnic | <input type="checkbox"/> Chinese | <input type="checkbox"/> Other Ethnic Category |

FURTHER DETAILS

Name and Relationship: _____

Contact No.: _____

Next of Kin _____ 2

Are you a Carer? YES NO

Name and relationship to you of person cared for _____ 3

Do you have a Carer? YES NO

Name and relationship to you of Carer _____

LIFESTYLE

• **SMOKING**

YES, I CURRENTLY SMOKE

NO, I DO NOT SMOKE 4

- How many do you smoke per day? _____
- What is the most you have smoked? _____
- How long have you smoked? _____
- Would you like to give up? _____
- Have you ever tried to give up? _____

- Have you ever smoked? _____
- If Yes, when did you give up? _____
- How much did you smoke per day? _____
- How long did you smoke? _____

• **EXERCISE**

Regular exercise is also very important for maintaining good health, whatever your age. 5

Do you think that you have a good exercise regime? Again, please be honest

I take inadequate exercise

I enjoy light exercise

I enjoy moderate exercise

I enjoy heavy exercise

Exercise is physically impossible

What is your height? _____ Weight? _____ (If you are unsure, please leave blank)

• **ALCOHOL**

Please answer the questions below by circling the appropriate option, then total the score. 6

One standard drink (unit) of alcohol is equal to a small glass of wine, a single measure of spirit such as gin or whisky or vodka, or half a pint of ordinary strength beer, lager or cider

SECTION 1 – Questions Please circle 1 answer for each question	Scoring system				
	0	1	2	3	4
1. How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
2. How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+
3. How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Please work out your score and write it in the box: Section 1 SCORE

- If the score is less than 5, please disregard Section 2 and continue to Section 3

- If the score is 5 or more, please answer the questions in Section 2

SECTION 2 – Questions <i>Please circle 1 answer for each question</i>	Scoring system				
	0	1	2	3	4
4. How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year

Please work out your score and write it in the box: Section 2 SCORE =

Combined Score of sections 1&2

3. PERSONAL MEDICAL HISTORY

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• **ILLNESSES, ONGOING CONDITIONS, FAMILY HISTORY**

Please indicate if you have, or if anyone in your family has ever had, any of the following conditions:

Condition	I have	Date Diagnosed	Family History of	Family member affected & at what age
Angina	Yes / No		Yes / No	
Heart Attack	Yes / No		Yes / No	
Stroke	Yes / No		Yes / No	
High Blood Pressure	Yes / No		Yes / No	
Other Heart or circulatory problem	Yes / No		Yes / No	
Thyroid problem	Yes / No		Yes / No	
Kidney problem				
Cancer	Yes / No		Yes / No	
Diabetes	Yes / No		Yes / No	
Epilepsy	Yes / No		Yes / No	
Asthma	Yes / No		Yes / No	
COPD	Yes / No		Yes / No	
Depression	Yes / No		Yes / No	
High Cholesterol	Yes / No		Yes / No	

When were you last seen by a Dr for any of the conditions listed in Section3? _____

Is there any other information that you think may be relevant in ensuring that your medical history is accurate and up to date – e.g. other illnesses, operations, accidents not covered in the list above?
 If so, please provide details here, including dates:

• MEDICATION

Do you take any tablets / use inhalers or other medication? YES / NO If Yes, please give details here:

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Name of Tablet or Medication	Dose	Why Taken?	Please tick how many months' supply you currently have left				
			Less than 1	1	2	3	3+

Please continue on a separate sheet if necessary. If you have a repeat prescription request form from your previous surgery, please bring it with you when you register.

Details of any Contraception: _____

• ALLERGIES

Do you have any allergies, including drug allergies? YES / NO

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If Yes, please give details _____

COMMUNICATION NEEDS

Do you need any support or help with communication? YES/ NO

If yes, what do you feel would help us to communicate? (please state for example I will need an interpreter, someone who can use sign language, documents in large print etc...)

IMPORTANT INFORMATION

- If you are on regular prescribed medication, you will need to make an appointment to see one of our Doctors for a prescription to be issued. Please make sure you make an appointment in plenty of time before any of your medication runs out.
- If you have any of the following conditions, you will be invited to attend an Annual Review in your birth month: Heart problem, Asthma, Kidney disease, COPD, Diabetes, Epilepsy, Hypertension, Thyroid disease, Stroke

Signed _____

Date _____

**Thank you for taking the time to fill in this questionnaire.
Please hand it in to Reception with your other registration documents.**