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 ______________

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______________ Postcode ______________

Telephone Numbers Home ______________ Work ______________

Mobile ______________

E-mail address ______________

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

Occupation ______________

Any children? ☐ YES ☐ NO

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

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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	☐ British ☐ Irish	☐ Other White background
Mixed	☐ White and Black Caribbean ☐ White and Black African	☐ White and Asian ☐ Other Mixed background
Asian or Asian British	☐ Indian ☐ Pakistani	☐ Bangladeshi ☐ Other Asian background
Black or Black British	☐ Black Caribbean ☐ Black African	☐ Other Black background
Other Ethnic	☐ Chinese	☐ Other Ethnic Category

FURTHER DETAILS

Next of Kin Name and Relationship: ______________________ Contact No.: ______________ 2

Are you a Carer? ☐ YES ☐ NO **Name of person cared for** ______________ 3

Do you have a Carer? ☐ YES ☐ NO **Name of Carer** ______________

LIFESTYLE

- **SMOKING** 4

☐ **YES, I CURRENTLY SMOKE**

- 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? ______________
- Would you like our Smoking Cessation Advisor to contact you about giving up? ________________

☐ **NO, I DO NOT SMOKE**

- Have you ever smoked? _____________________
- If Yes, when did you give up? ________________
- How much did you smoke per day? ___________
- How long did you smoke? ___________________

- **EXERCISE** 5

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

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**

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

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	**Scoring system**				
Please circle 1 answer for each question	**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 the questions below and continue on the next page**

- If the score is 5 or more, please answer the questions below:

SECTION 2 – Questions	**Scoring system**				
Please circle 1 answer for each question	**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 the above conditions? ___________________________

Is there any other information that you think may be relevant in ensuring that you 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**

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

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**

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

If Yes, please give details ______________________________

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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.