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New Patient Registration/Health Questionnaire

Personal Details

v.2015-10

Name……..DOB……

Contact no: Home……..Mobile……

Email…… Next of kin/Carer……

Marital Status……. Occupation……

Ethnicity…….. Preferred Language……

Interpreter required **Yes [ ] NO [ ]** Religion ……..

[ ]Religion **None** (code **135D)** **[ ]**Religion **Do not wish to answer** (code **135Q**)

Preferred method of communication: **[ ]Phone** Best tel.no. ……

[ ]Email [ ]Fax Fax no…… **[ ]Letter [ ]No preference**

I am giving my consent to contact me by either

Telephone **Yes [ ] NO [ ]** Email **Yes [ ] NO [ ]** Text Msg **Yes [ ] NO [ ]**

(Admin staff please enter the read code **9NdP** for **Yes** and **9NdQ** for **NO**)

Health Information

Smoking

Do you Smoke? **Yes [ ] NO [ ]** If **yes**, Cigarette [ ] Cigar [ ] Rolls [ ] Pipe [ ]

How many do you smoke a day? **[ ]**

Are you considering stopping smoking? **Yes [ ] NO [ ]**

If **Yes,** please make an appointment with practice nurse.

Diet

Are you vegetarian? **Yes [ ] NO [ ]**

Do you have varied diet including milk, meat, Vegetable and fruit? **Yes [ ] NO [ ]**

Do you add salt to your food after cooking? **Yes [ ] NO [ ]**

Exercise

Do you exercise? **Yes [ ] NO [ ]**

If **Yes,** How many times in a week and what do you do? ……

Allergy

Are you allergic to any medicine? **Yes [ ] NO [ ]** If Yes, Please write……

Are you allergic to any food? **Yes [ ] NO [ ]** If Yes, Please write……

Family History

Is any of your immediate family member has/had the history following diseases?

Stroke	**Yes [ ] NO [ ]**	If yes, who **.....**
Heart Disease	**Yes [ ] NO [ ]**	If yes, who **.....**
Diabetes	**Yes [ ] NO [ ]**	If yes, who **.....**
Asthma	**Yes [ ] NO [ ]**	If yes, who **.....**
Cancer	**Yes [ ] NO [ ]**	If yes, who **.....**

Past Medical History

Please give details of any hospital treatment as an in-patient:

……

Please give details of any treatment for any chronic medical conditions:

……

Immunisations

Dates of Triple/Polio/HIB……. Dates of Tetanus……..

Dates of MMR……. Dates of MenC……

For Female Patients Only

Date of Last Cervical Smear:…….. Result of last Smear:……

Medication

Are you currently on any medication? **Yes [ ] NO [ ]**

If yes, Please give details of your current medications.

Name of Drugs	**Doses**
…….....	…….
…….	…….
…….....	…….
…….	…….
…….....	…….
…….	…….

Alcohol

Do you drink alcohol? **Yes [ ] NO [ ]**

If yes, Please go to next page to fill up Alcohol Health Questionnaire.

Thank you for completing this questionnaire.

Alcohol Health Questionnaire (Audit-C)

Please tick (√) the relevant answers:

Score				
0	**1**	**2**	**3**	**4**
How often do you drink?				
Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
How many alcoholic drinks do you have on an average day? (Please count by the numbers above)				
1 -2	3 - 4	5 - 6	7 - 9	10+
How often do you have 6 or more alcoholic drinks? (Please count by the numbers above)				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
			Score	
If your Score 5 or more please answer the following questions.				
How often were you unable to control yourself taking another and another drink?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often did drinking prevent you from doing other things?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often did you need a drink in the morning to get you going (“eye opener”)?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often did you feel guilty or regret about drinking?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often were you unable to remember the night before?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or other people been injured because of your drinking?				
No		Yes, but not in the last year		Yes, during the last year
Have other people been worried about your drinking?				
No		Yes, but not in the last year		Yes, during the last year
			Total score	

Scoring: A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Thank you for completing this questionnaire.