

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 _____

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) _____

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"/> Other White background |
| | <input type="checkbox"/> Irish | |
| Mixed | <input type="checkbox"/> White and Black Caribbean | <input type="checkbox"/> White and Asian |
| | <input type="checkbox"/> White and Black African | <input type="checkbox"/> Other Mixed background |
| Asian or Asian British | <input type="checkbox"/> Indian | <input type="checkbox"/> Bangladeshi |
| | <input type="checkbox"/> Pakistani | <input type="checkbox"/> Other Asian background |
| Black or Black British | <input type="checkbox"/> Black Caribbean | <input type="checkbox"/> Other Black background |
| | <input type="checkbox"/> Black African | |
| 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 of person cared for _____

3

Do you have a Carer? YES NO

Name of Carer _____

LIFESTYLE

• **SMOKING**

4

YES, I CURRENTLY SMOKE

NO, I DO NOT SMOKE

- How many do you smoke per day? _____

- Have you ever smoked? _____

- What is the most you have smoked? _____

- If Yes, when did you give up? _____

- How long have you smoked? _____

- How much did you smoke per day? _____

- Would you like to give up? _____

- How long did you smoke? _____

- Have you ever tried to give up? _____

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

• **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**

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 <u>Please circle 1 answer for each question</u>	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 the questions below and continue on the next page

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

SECTION 2 – Questions <u>Please circle 1 answer for each question</u>	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 =

• **MEDICATION**

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**

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

If Yes, please give details _____

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.**