New Patient Questionnaire

Name______________________________ DoB ________________

We are required to obtain your permission to store your contact details. We will only contact you about appointments or matters relating directly to your healthcare, and we will only share your information in accordance with our Privacy Notice, details of which are available on our website and in our waiting room.

Home Telephone__________________________ Mobile Telephone_________________________

Email Address____

Please note: an email address is required from residents of caravan parks to enable us to send correspondence where regular postal deliveries are not accepted.

For non-dispensing patients only, please nominate a pharmacy for electronic prescriptions

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Record of Ethnicity and Main Spoken Language

Please tick the relevant boxes below.

Ethnicity

☐ White British ☐ British/Mixed British ☐ Irish
☐ Indian/British Indian ☐ Pakistani/British Pakistani ☐ Chinese
☐ Other (please specify ____

Language

☐ English ☐ Other (please specify) ______________________________

*By completing the following information on this questionnaire, you will be helping to ensure our records are kept up to date thus enabling us to offer you a higher level of care. Thank you.

Do you have any allergies? ☐ Yes ☐ No
If yes please specify ____

Other Information

Height (if known)__________________________ Weight (if known)_________________________

Smoking Status

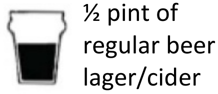
☐ Never smoked tobacco ☐ Ex-smoker – When did you quit? ____________________
☐ Current Smoker – How many per day? ________________________

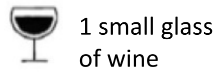
ADVICE: SMOKING KILLS: If you would like help to quit please call the Health Trainers Stop Smoking Service on 0800 917 7752, or see our Nurse Practitioner or your GP for advice.

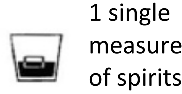
Alcohol Consumption

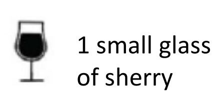
Please tick here if you do not wish to complete this section of the questionnaire (continued overleaf) ☐

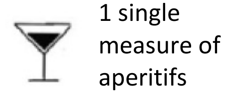
This is one unit of alcohol…


½ pint of regular beer lager/cider


1 small glass of wine


1 single measure of spirits


1 small glass of sherry

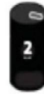

1 single measure of aperitifs

...and each of these is more than one unit

Pint of regular beer/lager/cider

Pint of premium beer/lager/cider

Alcopop or can/bottle of regular lager



Can of premium lager or strong beer

Can of super strength lager

Glass of wine (175ml)

Bottle of wine

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2-4 times per month ☐	2-3 times per week ☐	4+ times per week ☐	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2 ☐	3-4 ☐	5-6 ☐	7-9 ☐	10+ ☐	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily/ Almost daily ☐	

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

Total Score:

P.T.O

Do you have any significant personal medical history? ☐ Yes ☐ No
If yes, please specify ______________________________

Do you have any significant family medical history? ☐ Yes ☐ No
If yes, please specify ______________________________

Are you taking any regular medication? ☐ Yes ☐ No
If yes, please list here ______________________________

Are you a carer? ☐ Yes ☐ No
If yes, who do you care for? ______________________________

Patient Signature: ____________________ **Date:** ____________________

I confirm that the information provided above is accurate at the date of completion. I consent to my contact details being stored in accordance with GDPR and Data Protection Act 2018 and to being contacted by SMS text messaging.

If you would like to join our patient reference group, please ask at reception

Score from AUDIT-C: Total Score:

Remaining AUDIT questions

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐	
Have you or somebody else been injured as a result of your drinking?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐	
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No ☐		Yes, but not in the last year ☐		Yes, during the last year ☐	

Scoring: 0-7 Lower risk, 8-15 Increasing risk, 16-19 Higher risk, 20+ Possible dependence

TOTAL Score equals AUDIT-C score + score of remaining questions

Total score: