NEW PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE

Please fill out everything which is relevant to you

Forname(s):	
Surname:	
Date of Birth:	
Ethnic Origin:	
Address:_____ _____Postcode:_____	
Home tel:	Mobile:
Email address:	
Occupation:	

LIFESTYLE	Height (approx)? ft cm	Weight (approx)? St Kg
Do you smoke? ☐ Never smoked ☐ Ex-smoker ☐ Smoke_____daily If you are an Ex-smoker how many did you smoke daily? _____ Are you exposed to smoke at work or home if so which one? _____ If you would like to stop, please ask reception for details of Smoking Cessation Services.		
Do you take regular exercise? ☐ Yes ☐ No If yes, what sort of exercise? _____ If yes, on average how many hours per week? _____		

FAMILY HISTORY	Please state any significant family medical history below		
Illness/Condition	1.	2.	3.
Family member			
Aged diagnosed			

MEDICAL HISTORY	Please tick if you have ever suffered or been treated for any of the following:
☐ Asthma ☐ Epilepsy ☐ Diabetes ☐ High Cholesterol ☐ Mental Illness ☐ COPD ☐ Stroke ☐ High BP ☐ Heart Disease ☐ Thyroid Disorder ☐ Cancer of_____ ☐ Other _____	
If you have any chronic or significant medical condition, please ensure you have at least two-four weeks' worth of medication from your previous surgery until we can fully register you.	

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MEDICATION	Please give details of any medication which you take (Prescribed)
Name of drug:	Dosage:
Name of drug:	Dosage:
Name of drug:	Dosage:
Name of drug:	Dosage:
Name of drug:	Dosage:
Name of drug:	Dosage:
Name of drug:	Dosage:

Please bring a recent repeat prescription to your health check appointment, to avoid any delays. All prescriptions take two clear working days upon request.

Allergies or Reactions	Give details if you have had an allergic reaction anything previously

Do you have any specific needs? Please give details below

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
If "Yes" Would you like them to deal with your health affairs here? Yes / No
(The receptionist can help with these arrangements)

Do you care for anyone else? Yes / No
If "Yes" ask the receptionist about Carers support

FEMALE PATIENTS ONLY AGED 24-64	Please be as accurate as possible. It is **mandatory requirement** a cervical smear is arrange for you at the practice unless you are able to provide a copy of your results within the past 12 months.
Have you had a cervical smear test in the last 3 years?	Yes / No
Date of most recent cervical smear?	
Disclaimer Signed:_____	

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Alcohol Consumption Questionnaire

Questions about your Alcohol Consumption	0	1	2	3	4	Your score
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 or almost daily	
If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below.						
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 from 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 results of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Total AUDIT Score (Questions 1-10:

If you are concerned about your consumption of alcohol, please book an appointment with a doctor once you are registered.

I the named patient above confirm that I have completed this form as accurately and honestly as possible. I will attend all appointments made for me with the clinical staff and will arrive on time. If needed I will cancel and rebook 24 hours prior to my appointment to allow time for other patient's to use if needed. I accept all responsibility if not arriving on time and therefore if I can't be seen when arriving I'm aware I will need to rebook.

Signature:_____ Date _____/_____/_____