**BUCKDEN AND LITTLE PAXTON SURGERY**

**NEW PATIENT QUESTIONNAIRE** By completing this questionnaire, you will help us to know a little about you until we receive your full medical records.

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname:** | | First Names | |
| Previous Surname: | | Date of Birth: | |
| Marital Status: | | Occupation: | |
| Address:  Post Code: | | Home Tel No: | |
| Mobile Tel No: | |
| Email: | |
| Next of Kin: | | Next of Kin Tel No: | |
| Do you have a carer? | Yes / No | Are you a carer? | Yes / No |
| Carer’s name | | Carer’s Tel No: | |

**COMMUNICATION NEEDS** - Accessible Information Standard

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have hearing impairment? | Yes / No | If yes, any detail: | |
| Do you have learning disabilities? | Yes / No | If yes, any detail: | |
| Do you have a visual impairment? | Yes / No | If yes, any detail: | |
| **If yes,** what help (if any) do you need communicating?  (e.g. hearing loop, large print, emails) | | | |
| Do you give consent to share any communication needs with other health care professionals? | | | Yes / No |

**YOUR HEALTH** Have you ever suffered from? (please delete)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Epilepsy | Yes / No | Heart Attack | Yes / No | Strokes or TIA | Yes / No |
| Diabetes | Yes / No | Angina | Yes / No | Blindness | Yes / No |
| Asthma | Yes / No | Blood Pressure | Yes / No | Glaucoma | Yes / No |

**MEDICINES** Please list what tablets or medicines you are taking (or put none)

|  |  |  |
| --- | --- | --- |
| Name | Strength | Dose Frequency (eg one daily) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Are **YOU ALLERGIC** to any tablets, Medicine or Injections? Yes / No

**If yes**, please list and say what happens:

|  |  |  |
| --- | --- | --- |
| Name of Medicine | Type of Reaction | Date |
|  |  |  |
|  |  |  |

Page 1

**FAMILY HISTORY** Have **any of your relations** had any of the following?

|  |  |  |
| --- | --- | --- |
| Disease or Illness |  | Which relation. Over or Under 60? |
| Heart attack / Angina | Yes / No |  |
| Stroke | Yes / No |  |
| High Blood Pressure | Yes / No |  |
| Diabetes | Yes / No |  |
| Asthma | Yes / No |  |
| Cancer of the: Breast  Bowel  Cervix  Other: Site : | Yes / No  Yes / No  Yes / No  Yes / No |  |

ABOUT YOUR **ETHNIC BACKGROUND**

Tick here if you do not want to give this information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **WHITE** | | **ASIAN** | | **BLACK** | | **MIXED** | |
| British |  | Indian |  | African |  | White/African |  |
| Irish |  | Bangladeshi |  | Caribbean |  | White/Asian |  |
| European |  | Pakistani |  | Other Black |  | White/Caribbean |  |
| Other White |  | Chinese |  |  | | Other Mixed |  |
|  | | Other Asian |  |  | |

IS ENGLISH YOUR **FIRST LANGUAGE**? Yes / No

If NO what is your main spoken language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO HAS **PARENTAL RESPONSIBILITY** (FOR CHILDREN UNDER 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOBACCO** Please complete the box below:

|  |  |  |
| --- | --- | --- |
| Smoking Status | Please tick all that apply | Please indicate how many smoked per day and date gave up (If appropriate) |
| Never Smoked tobacco |  |  |
| Current Smoker |  |  |
| Ex-Smoker |  |  |
| Pipe Smoker |  |  |
| Cigar Smoker |  |  |
| Rolls own cigarettes |  |  |
| Cigarette Smoker |  |  |

**If you smoke**, are you currently thinking about giving up? Yes / No

**If yes**, call the local smoking helpline on 01480 418693 or visit [www.camquit.nhs.net](http://www.camquit.nhs.net) or book an appointment to see one of the practice nurses for advice.

**ALCOHOL** How many **units** per week? units/wk

Please complete attached Alcohol Questionnaire if you are aged 15 or older.

**GENERAL QUESTIONS**

What is your **height**? \_\_\_ft \_\_\_ins or \_\_\_\_\_metres

What is your **weight**? \_\_\_st \_\_\_lbs or \_\_\_\_\_kg

Do you take regular **Exercise**? Yes / No Type (eg walk, swim, gym etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN ONLY**

Have you ever had a **cervical smear?** Yes / No When \_\_\_/\_\_\_/\_\_\_\_

Was the result negative? Yes / No When is your next smear due? \_\_\_/\_\_\_/\_\_\_\_

Have you had a **hysterectomy?** Yes / No

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

ADMIN USE ONLY Template completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Scanned by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Page 2

**ALCOHOL CONSUMPTION QUESTIONNAIRE (AUDIT-C/AUDIT)**

**Please circle the answer that is correct for you**

How often do you have a drink containing alcohol?

* Never 0
* Monthly or less 1
* 2-4 times a month 2
* 2-3 times a week 3
* 4 or more times a week 4

How many standard drinks containing alcohol do you have on a typical day when drinking?

* 1 or 2 0
* 3 or 4 1
* 5 or 6 2
* 7 to 9 3
* 10 or more 4

How often do you have six or more drinks on one occasion?

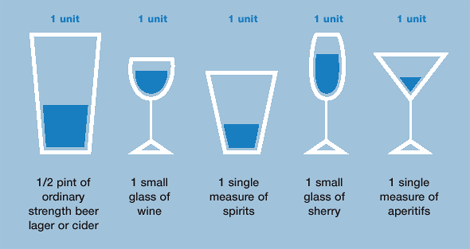
* Never 0
* rarely 1
* Monthly 2
* Weekly 3
* Most days 4

\_\_

Total:

**If total more than 5, please complete additional questions overleaf**

**What is a standard unit of alcohol?**



(3.5% abv) (125ml) of (25ml) of (50 ml)

wine (8% abv) spirits of fortified

(40% abv) wine (20%

Abv)

Page 1

**ALCOHOL CONSUMPTION QUESTIONNAIRE (AUDIT-C/AUDIT)**

During the past year, how often have you found that you were not able to stop drinking once you had started?

* Never 0
* Less than monthly 1
* Monthly 2
* Weekly 3
* Daily or almost daily 4

During the past year, how often have you failed to do what was normally expected of you because of drinking?

* Never 0
* Less than monthly 1
* Monthly 2
* Weekly 3
* Daily or almost daily 4

During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

* Never 0
* Less than monthly 1
* Monthly 2
* Weekly 3
* Daily or almost daily 4

During the past year, how often have you had a feeling of guilt or remorse after drinking?

* Never 0
* Less than monthly 1
* Monthly 2
* Weekly 3
* Daily or almost daily 4

During the past year, have you been unable to remember what happened the night before because you had been drinking?

* Never 0
* Less than monthly 1
* Monthly 2
* Weekly 3
* Daily or almost daily 4

Have you or someone else been injured as a result of your drinking?

* No 0
* Yes, but not in the past year 2
* Yes, during the past year 4

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

* No 0
* Yes, but not in the past year 2
* Yes, during the past year 4

Score from this page \_\_\_\_

Score from previous page \_\_\_\_

**TOTAL** \_\_\_\_

**Scoring the audit**

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Page 2