

Huthwaite Medical Practice New Patient Questionnaire

Personal Details

Full Name			Date of Birth		
Previous Name			NHS Number		
Address			Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female
			Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Co-habiting
				<input type="checkbox"/> Widowed	<input type="checkbox"/> Single
				<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
Postcode					
Telephone Number	(Home) _____ (Work) _____ (Mobile) _____	ID required	<input type="checkbox"/> photo address	<input type="checkbox"/> please tick	
Consent for Text Messaging Service			Yes <input type="checkbox"/>	No <input type="checkbox"/>	

E-mail address:

Ethnic Group (please tick)	<input type="checkbox"/> British or mixed British	<input type="checkbox"/> Other (please state)
	<input type="checkbox"/> White Irish	
	<input type="checkbox"/> White other ethnic group	
	<input type="checkbox"/> Asian other ethnic group	Language (please state main language spoken)
	<input type="checkbox"/> Black other ethnic group	

Have you been in the Armed Forces?
If yes did you sustain any injuries (please give details)

Next of Kin or Carer Details (please tick the box if they are your carer)

Full Name			Relationship to You		
Address			Contact Number and other details		

Lifestyle Information

Do you Smoke?	<input type="checkbox"/> Never <input type="checkbox"/> Stopped Smoking (date stopped smoking) _____ <input type="checkbox"/> Yes (how many): _____	Do you Drink Alcohol?	<input type="checkbox"/> If yes please complete attached form. <input type="checkbox"/> No
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Height	<input type="text"/>	ft	<input type="text"/>	ins	<input type="text"/>	m	Weight	<input type="text"/>	st	<input type="text"/>	lbs	<input type="text"/>	Kg
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Medical History

Do you suffer with any of the following?	<input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Chest disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart attack/disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Mental health problems <input type="checkbox"/> Other - details _____	Please give details including dates
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PLEASE TURN OVER TO COMPLETE THE QUESTIONNAIRE

Do you have a repeat prescription from your previous GP
If yes please hand it in.

YES NO

Are you currently under hospital care?	Hospital Name					
	Consultant					
	Nature of Problem					
The doctor may discuss with you the possibility of transferring your care to a local hospital						
Important Allergies	Please include details of the reaction					
Family History		Have your Parents, Brothers or Sisters had any of the following?	Relationship	Age of Onset	Sex	M/F
Please Tick	<input type="checkbox"/>	Diabetes				
	<input type="checkbox"/>	Heart Attack/Angina				
	<input type="checkbox"/>	Stroke				
	<input type="checkbox"/>	Bowel Cancer				
	<input type="checkbox"/>	Breast Cancer				
	<input type="checkbox"/>	Ovarian cancer				
	<input type="checkbox"/>	Thrombosis				

Females Only					
Children	Number		Miscarriages or Terminations	Please give details and dates below	
	Ages				
Current method of family planning	<input type="checkbox"/>	None	<input type="checkbox"/>	Coil	
	<input type="checkbox"/>	Pill	<input type="checkbox"/>	Injection	
	<input type="checkbox"/>	Condom	<input type="checkbox"/>	Implanon	
	<input type="checkbox"/>	Sterilisation	<input type="checkbox"/>	Hysterectomy	
	<input type="checkbox"/>	Partner had vasectomy			
Do you receive your contraception from the Family Planning Clinic?			YES	<input type="checkbox"/> NO	<input type="checkbox"/>

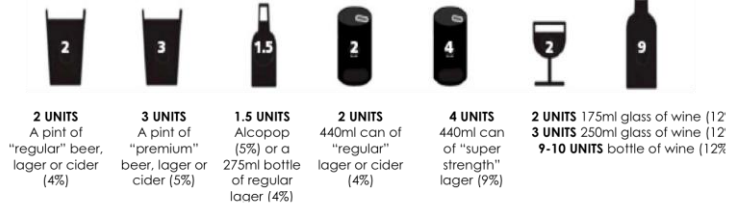
PLEASE REMEMBER TO HAND IN YOUR REPEAT MEDICATION RE-ORDER SLIP FROM YOUR PREVIOUS GP

Alcohol Health Questionnaire – HUTHWAITE HEALTH CENTRE

Instructions for Patients:

Please circle the correct answers and then hand into a member of the practice staff.

The unit guide below will help with calculating units.



Questions	Scoring system					Your score
	0	1	2	3	4	
1. 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	
2. How many units of alcohol do you drink on a typical day when you are drinking? (<i>See unit guidance above.</i>)	1-2	3-4	5-6	7-9	10+	
3. 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	
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	
5. 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	
6. 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	
7. 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	
8. 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	
9. 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	
10. 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 _____						