Dr Aru & Partners Practice

**NEW PATIENT REGISTRATION - HEALTH QUESTIONNAIRE**

**Please complete this questionnaire as fully as possible. The information is important as it will help the doctor to make an initial assessment of your health.**

**TODAY’S DATE………………………………………….**

**SURNAME………………………………………………..FORENAMES………………………………………………………………….**

**DATE OF BIRTH…………………………………………**

**ADDRESS……………………………………………………………………………………………………………………………………………………………………………………………………………POSTCODE……………………………………………………………………**

**HOME TELEPHONE……………………………………MOBILE………………………………………………………………………..**

**E-MAIL ADDRESS…………………………………………………………………………………………………………………………….**

**OCCUPATION…………………………………………………………………………………………………………………………………..**

**NAMES OF OTHER FAMILY MEMBERS AT SAME ADDRESS…………………………………………………..............**

**……………………………………………………………………………………………………………………………………………………….**

**NEXT-OF-KIN……………………………………………………………………………………………………………………………………**

**RELATIONSHIP TO PATIENT……………………………………………CONTACT DETAILS……………………………………**

**……………………………………………………………………………………………………………………………………………………….**

**HAVE YOU EVER BEEN REGISTERED AT THIS PRACTICE BEFORE? YES/NO**

**IF ‘YES’ WHICH PRACTICE?.................................................................................................................**

**HIV TESTING**

**We routinely offer HIV testing to all new patients aged over 16.**

**Would you like an HIV blood test? YES/NO**

**PLEASE READ THE FOLLOWING:**

**We use text messaging to remind you of appointments and health checks that may be due. To opt out of receiving these alerts please tick the box**

**If you would like to register to use our on-line prescription ordering service please tick the box**

**We have a Patient Participation Group which meets 3 or 4 times a year. If you would like to join this group please tick the box and state how you would like to be contacted.**

**I would like to be contacted by: PHONE/E-MAIL/LETTER**

**HEALTH QUESTIONS**

**HEIGHT…………………………………..……………………..WEIGHT……………………………………………………………..**

**SMOKING**

**DO YOU SMOKE? YES/NO IF ‘YES’ HOW MANY:**

**Cigarettes per day……….…..cigars per day……………….ounces of tobacco per day………………………..**

**How old were you when you started smoking?..........................................................................**

**EX-SMOKERS**

**How old were you when you stopped smoking?........................................................................**

**How many did you smoke per day?............................................................................................**

**PASSIVE SMOKING**

**Are you exposed to other people’s smoke? YES/NO**

**DIET**

**Do you add salt to your food after cooking? YES/NO**

**Do you eat 5 servings of fruit and vegetables per day? YES/NO**

**If aged over 40, have you had an NHS Health check? YES/NO**

**EXERCISE**

**Do you take regular exercise? YES/NO**

**If ‘YES’ what sort of exercise?............................................................................................................**

**How many times per week?............................................................................................................**

**FAMILY HISTORY**

**Is there any of the following in your family (father, mother, brother, sister), before the age of 65?**

**Heart Disease (heart attacks/angina YES/NO Which family member?........................................**

**Stroke YES/NO Which family member?..............................................................**

**Cancer YES/NO Which family member?..................................................................................**

**MEDICATION**

**Please give details of any medication you take (prescribed or otherwise).**

**NAME OF DRUG: NAME OF DRUG:**

**DOSE: DOSE:**

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**DOSE: DOSE:**

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**DOSE: DOSE:**

**NAME OF DRUG: NAME OF DRUG:**

**DOSE: DOSE:**

**If you receive repeat medication please bring your repeat prescription slip from your previous doctor when you attend for your New Patient Health Check.**

**ALLERGIES**

**Are you allergic to any medicines or foods? YES/NO**

**IF ‘YES’ PLEASE GIVE DETAILS………………………………………………………………………………………………………….**

**CURRENT MEDICAL CONDITIONS**

**Are you currently undergoing or awaiting hospital treatment? YES/NO**

**If ‘YES’ please give details:………………………………………………………………………………………………………….**

**Do you have any medical conditions? YES/NO**

**If ‘YES’ please give details……………………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………………………………..**

***FEMALE PATIENTS ONLY***

**Date of your last cervical smear………………………………………………………………………………………………….**

**Result………………………………………………………………………………………………………………………………………..**

**ALCOHOL QUESTIONNAIRE**

**Please complete the following questionnaire.**

**This is one unit of alcohol…**

**Half pint of regular beer lager or 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**

**2 pint of regular beer lager cider 3 pint of premium beer lager coder 1.5 alcopop or can bottle of regular lager 2 440ml can of premium lager or strong beer 4 440ml can of super strength lager 2 glass of wine 175ml 9 bottle of wine**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FAST** | **Scoring system** | | | | | **Your score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |
| **Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).** | | | | | | |
| 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 been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| 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 |  |

**Scoring:**

If score is 0, 1 or 2 on the first question

continue with the next three questions

If score is 3 or 4 on the first question – stop here.

**An overall total score of 3 or more is FAST positive**.

**SCORE**

**What to do next?**

If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions below) to obtain a full AUDIT score.

**Remaining AUDIT questions**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 - 8 | 10+ |  |
| 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 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 |  |
| 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 |  |

**TOTAL AUDIT Score (all 10 questions completed):**

0 – 7 Lower risk,

8 – 15 Increasing risk,

16 – 19 Higher risk,

20+ Possible dependence

**TOTAL**

1. Are you a carer? – Do you help a friend or relative live their daily life?

Yes**/**No

**2.** Are you cared for? Do you have a friend or relative who helps you with your daily life? Yes **** No ****

3. What do you consider to be your national identity?

……………………………………………………

4. What is your country of birth?

…………………………………….......................

5. What is your main spoken language?

……………………………………………………

6. What language do you prefer to read?

…………………………………………………....

Do you need an interpreter or translator? Yes/ No

Can you read English?

7. Do you need large print? Yes **** No ****

8. Do you use lip reading? Yes **** No ****

9. Do you use text phone/ minicom? Yes **** No ****

Please tell us your ethnic group. Please choose ONE section only form A to E. If you tick the other please write your ethnic group in the space given.

|  |  |
| --- | --- |
| A Asian or Asian British  □ Bangladeshi  □ Indian  □ Pakistani  □Other Asian background  Please write in ………………………………….. | D. Mixed Background  □ White& Asian  □ White & Black African  □ White & Black Caribbean  □ Any other mixed back ground please write in………………………………….. |
| B Black or Black British  □Africa  □Caribbean  □ Any other Black background  please write in………………………………….. | E. White  □British  □Irish  □ Any other White background please write in…………………………………. |
| C Chinese or other ethnic groups  □Chinese  □Any other ethic group please  Please write in………………………………….. | F. Please write in any other background……………………………... |

Please list any other information that you feel the practice should be aware of.

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