

## NEW PATIENT & LIFESTYLE QUESTIONNAIRE

To enable our practice to provide services that suit patient needs, we would be grateful if you could complete this questionnaire.  
Your answers will be treated in the strictest confidence.  
Please circle your choices where applicable.

NAME..... DATE OF BIRTH.....

Male / Female Title: Mr / Mrs / Dr / Ms / Master. Other.....

ADDRESS.....

POSTCODE..... TEL. NO.....

HOME NO. ....

MOBILE NO. ....

**PERSONAL STATUS:** Married / Single / Divorced / With Partner / Widowed

Are you a Carer? YES / NO.....Next of Kin / Carer:.....

Next of Kin Relative e.g Father.....Emergency Tel No.....

**ETHNIC GROUP:** White / Indian / Chinese / Black Caribbean / Pakistani / Bangladeshi / Other Asian / Black African / Other:.....

\*\*\*\* **Do you require an interpreter?** Y/N \*\*\*\*

**LANGUAGES SPOKEN:** English / Hindi / Bengali / Gujarati / Punjabi / Urdu / Pushtu / Arabic / Swahili / Kurdish / Farsi / French / Spanish / German / Other.....

COUNTRY OF BIRTH..... RELIGION.....

HEIGHT..... WEIGHT.....

**Are you currently:** EMPLOYED / UNEMPLOYED / RETIRED / STUDENT

JOB TITLE (if employed)..... PART-TIME / FULL-TIME

**EXERCISE:** Do you take part in some form of regular exercise? YES / NO

NONE / LIGHT / MODERATE / HEAVY If yes, please give details.....

**ARE YOU A SMOKER?** PRESENT / PAST / PASSIVE / NEVER

If yes: How many per day?.....

Do you smoke: Cigarettes / Cigars / Pipe / Other.....

If you used to smoke, when did you stop?.....

How many years did you smoke? ..... How many did you smoke?.....

**You may already be aware that smoking is the most important cause of avoidable illness and premature death in the UK.**

If you do smoke, would you be interested in receiving some information about helping you to stop smoking? YES / NO

**HOW MUCH ALCOHOL DO YOU DRINK PER WEEK ON AVERAGE?**

None.....Wine.....Beer.....Spirits.....Other.....  
.....

1 pint = 2 Units

**Recommended sensible drinking limits are less than 21 Units per week for men and less than 14 Units per week for women – spread throughout the week.**

**Blood Pressure reading :..... (please use machine in waiting room)**

**ARE YOU TAKING ANY MEDICATION (including contraception)? YES / NO**

**\*\*PLEASE BRING OLD REPEAT SLIP FROM LAST PRACTICE\*\***

**If yes please list names (and doses):.....**  
.....  
.....

**HAVE YOU ANY ALLERGIES TO MEDICINE OR ANYTHING ELSE?**

**Medicine:.....Other.....**

**DIET: Normal / Vegetarian / Vegan / Other.....**

- Do you suffer from**
- high blood pressure ? YES / NO.....
  - Heart disease ? YES / NO.....
  - Asthma ? YES / NO.....
  - Stroke ? YES / NO.....
  - Diabetes ? YES / NO.....
  - Mental Health problems ? YES / NO.....
  - Thyroid gland problems ? YES / NO.....
  - Skin conditions ? YES / NO.....
  - Cancer ? YES / NO.....
  - Kidney problems? YES / NO.....
  - OTHER.....

**HAVE YOU EVER HAD A SURGICAL OPERATION? PLEASE LIST & DATE.....**  
.....

**HAVE YOU EVER HAD A TETANUS INJECTION? YES / NO**

**IF YES WHEN (approx)?.....**

**ILLNESSES IN YOU FAMILY**

<b>ILLNESS</b>	<b>YES / NO</b>	<b>RELATIVE and Age diagnosed</b>
<b>Cancer (Type.....)</b>	<b>YES / NO</b>	
<b>Heart disease/Angina</b>	<b>YES / NO</b>	
<b>High Blood Pressure</b>	<b>YES / NO</b>	
<b>Stroke</b>	<b>YES / NO</b>	
<b>Diabetes</b>	<b>YES / NO</b>	
<b>Asthma</b>	<b>YES / NO</b>	
<b>Mental illness (Type.....)</b>	<b>YES / NO</b>	

**Other illnesses run in your family? Who?**

.....

**CHILDREN - IMMUNISATIONS** (If under 5 years please bring Red Book)

**Is your child up-to-date with all immunisation /vaccinations?**

YES / NO / NOT SURE

If NOT SURE, discuss with practice nurse or Health Visitor at the practice.

**FOR FEMALE PATIENTS ONLY**

Have you had any children? YES / NO If yes, how many?.....Ages.....

Have you had a miscarriage? YES / NO Date.....

Have you had a Hysterectomy? YES / NO Date.....

Do you use any form of contraception? YES / NO Which type?.....

When was your last smear?.....Result?.....

\*\*\*\*\*

**Internet Access:** YES / NO

Email address:

Does ONLY you have access to your email? YES / NO

Would you be interested in email correspondence with your GP, for notification of results etc? YES / NO

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.**

**Sky Blue Medical Group offers internet appointment booking, please ask at your local surgery.**

**Once registered, using EMIS Access, you can now view, book and cancel appointments at your local GP surgery from home, work or on the move – wherever you can connect to the internet. What’s more, because EMIS Access is a 24 hour online service – you can do this in your own time, day or night.**

**Plus, EMIS Access is not just for booking GP appointments - the popularity of online appointment booking has led to more online features being added, including:**

- Repeat prescription ordering
- Change of address (Please check you remain within our catchment area)
- Secure message facility

**For more information on the features of EMIS Access and how to register see our website or ask at reception.**

**WHEN RETURNING THE FORM FOR  
REGISTRATION PLEASE DO SO AFTER  
3.00pm.**

# AUDIT (Alcohol Use Disorders Identification Test)

This questionnaire was developed by the World Health Organisation to identify persons whose alcohol consumption has become hazardous or harmful to their health.

FOR EACH QUESTION SELECT YOUR ANSWER AND FILL IN THE SCORE GIVEN IN BRACKETS [ ] IN THE BOX

One unit of alcohol is: ½ pint average strength beer/lager OR one glass of wine OR one single measure of spirits. Note: a can of high strength beer or lager may contain 3-4 units. (See the Aquarius Unit Reckoner fact sheet for more information about units of alcohol.)

1. How often do you have a drink containing alcohol?

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

2. How many units of alcohol do you drink on a typical day when you are drinking?

[0] 1 or 2 [1] 3 or 4 [2] 5 or 6 [3] 7, 8 or 9  
[4] 10 or more

3. How often do you have six or more units of alcohol on one occasion?

[0] Never [1] Less than monthly [2] Monthly  
[3] Weekly [4] 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?

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

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

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

continues ...

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

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

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

[0] Never    [1] Less than monthly    [2] Monthly  
[3] Weekly    [4] 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?

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

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

[0] No    [2] Yes but not in the last year  
[4] Yes, during the last year

10. Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?

[0] No    [2] Yes but not in the last year  
[4] Yes, during the last year

**Record total of specific items here**

If total over 8, alcohol use disorder very likely

**If you scored positive and would like to read some suggestions about what to do next, close this document (save it to disk first if you like) and return to the front page of the *About Drinking Problems* section of the Aquarius website.**