Amended 22.4.2015

LONG BENNINGTON MEDICAL CENTRE NEW PATIENT QUESTIONNAIRE

This set of questions has been designed to help your new General Practitioner get to know you and your medical problems. The information you provide will be handled confidentially by your doctor, but if you are concerned about any of the questions please leave them blank. Your doctor or nurse will be pleased to clarify any points. Please return to the surgery along with your registration form.

Date Completed…… Title…….

Surname…… Forename(s)……..

Date of Birth……. Marital Status…….

Address……. ……..

Tel No…… Mobile…….....

Email address……

Ethnic Origin…… First Language……...

Occupation…….

Are you a carer? Yes / No If so, for who?.....

Do you have a carer? Yes / No Name……. ……..

Carer's Contact Details…….

Are you a military veteran?.....Yes/No

Were you on the Unplanned Admissions Register at your previous Surgery? ……. Yes/No

If Yes, did you have a Care Plan in place?..... Yes/No

PAST MEDICAL HISTORY

Please list all serious illnesses, accidents, hospital admissions or **operations** with dates and details of hospital if known. If female, include any pregnancy complications. Please also list any current illnesses which you have.

MEDICATION: Please give details of any medication, with doses, which you take (prescribed or otherwise). Please include contraception if relevant. When you see your doctor, if possible bring along an old repeat prescription, or your actual medication if you do not have this.

Are you allergic to any medications, substances or foods? Yes / No

If yes, please give details.……

FAMILY HISTORY

Please state if any of your family have, or had, any of the following conditions, and at what age they were first diagnosed with them:-

Heart Disease (heart attacks, angina) Yes / No Who?..... Age?.....

Stroke Yes / No Who?.....……Age?...…….

Diabetes Yes / No Who?..... Age?.....

Cancer Yes / No Who?..... Site of cancer?..... Age?.....

Any other relevant family history?…….

……..

LIFESTYLE

Do you consider your diet healthy? Yes / No / Not sure

Do you take regular exercise? Yes / No

If yes, what sort of exercise? ……..…… How many times per week? ……

SMOKING

Do you smoke? Yes / Ex-smoker / Never

If Yes, how many per day?.....Cigarettes……Cigars……..Oz Tobacco

How old were you when you started smoking? ……

If an ex smoker, when did you stop? …… How much did you smoke?.....

ALCOHOL

We are increasingly aware of the potential dangers of drinking excess alcohol. The questions on the next page help us assess whether you are at risk from your drinking. Please answer and score each question and then add up your total. If your drinking is of concern, this will be addressed at your new patient check with the nurse.

On average how many units of alcohol do you drink per week? …… units

Please note, 1 unit equals half a pint of standard strength beer, 1 small glass of wine or a single pub measure of spirits.

ANY OTHER INFORMATION WHICH YOU FEEL MAY BE USEFUL

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Alcohol Use Disorders Identification Test

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 drinks containing alcohol do you have on a typical day of drinking?	1 -2	3 - 4	5 – 6	7 - 9	10+	
How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 result 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	

YOUR TOTAL SCORE ☐

Thank you for completing this questionnaire. Your doctor or nurse will assess the information provided and will invite you for an initial examination, discussion about your health, and general check.