New Patient Health Questionnaire

Wigton Group Medical Practice

Please complete this form for our records (one for each member of the family).

Full Name:		**Date of Birth:**	

Country of birth: _____

What is your first language? _____
Do you require an Interpreter? Yes ☐ No ☐

Marital status? Single ☐/Married ☐/Divorced ☐/Widowed ☐/ Rather not say ☐

Contact Details:
Home telephone number: _____

Mobile number: _____

Email address: _____

I do/do not give consent to receive text messages (to the mobile number provided above) from the surgery, this may include messages from your GP/appointment reminders (please circle choice and sign below):

Signature: _____

Have you ever been registered with the practice before either under your current name or a previous name? (Please tell us your previous name)

Please indicate your ethnic origin. This is not compulsory but may help your health care as some conditions are more common in specific communities. (Please circle your answer below).

White - British☐ White - Irish☐ Black – Caribbean☐ Black – African☐ Black – British☐ Indian☐

Pakistani☐ Bangladeshi ☐ Chinese ☐ Asian – Other☐ Other ☐ – please specify_____

What is your Occupation? _____

Have you ever served in the armed forces? Yes ☐ No ☐ If so please state when_____

Are you a family member of a serving armed forces personnel? Yes ☐ No ☐

Are you a family member of a former armed forces personnel? Yes ☐ No ☐

Are you a Carer for another person? Yes ☐ No ☐

(A Carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.)

Do you have a Carer? Yes ☐ No ☐

Carer's details: Name: _____

Relationship to you: _____

Contact Number: _____

P.T.O

Are you housebound? Yes ☐ No ☐

Who can we contact in an emergency?	**Name:** **Contact Number:** **Relationship to you:**

Do you have any current health problems?

Please list any important illnesses or operations in the past (Please give dates if you can)

Are you currently under hospital follow-up or awaiting a hospital appointment? Yes ☐ No ☐
If yes, please give details below:

Are you on any regular treatment/medication? Please list below. If you have a repeat prescription list please enclose this instead.

Name of Medication	Dosage	How many times a day?

Were you signed up for electronic prescribing at your previous practice? Yes ☐ No ☐

Do you have any known allergies? please list below any allergies you have including medication, substances and food.

Are you up to date with your immunisations? Yes ☐ No ☐ – if no, which are required?

(If known) please tell us your height _____ and weight _____

Smoking Status:
Current Smoker ☐ & how many a day? …….. Ex-smoker ☐ Never Smoked ☐
Electronic cigarette user ☐

P.T.O

Please indicate any known family history below and where possible which family member.			
Family History:	**Yes**	**No**	**Family Member:**
Bowel Cancer			
Breast Cancer			
Diabetes			
Stroke			
Heart Disease diagnosed at under 60 years of age			
Heart Disease diagnosed at over 60 years of age			
Other significant family history – please specify. **_____**			

Women Only

Are you up-to-date with your cervical smears? Yes ☐ No ☐

Are you currently using any contraception? Yes ☐ No ☐ Please give details below.

_____

How much physical exercise do you do in a week? (please tick below)

None ☐ Some but less than 1 hours/week ☐
1-3 hours/week ☐ More than 3 hours/week ☐

How much physical activity is involved in your work/usual weekly activities? (circle answer)

Sedentary – spend most of time sitting e.g. work in an office

Standing – spend most of time standing or walking e.g. shop assistant, hairdresser, childminder, security guard etc

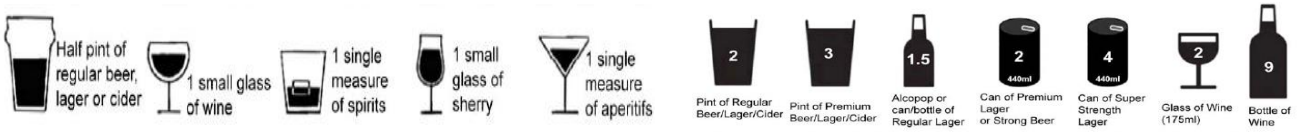
Physical – work involves physical effort, handling heavy objects and use of tools e.g. plumber, electrician, joiner, cleaner, gardener, hospital nurse, postal delivery workers etc

Heavy Manual – work involves handling of heavy objects e.g. scaffolder, construction worker, refuse collector etc

Please note if any of your personal details change, please inform the surgery so we can keep your details up to date……thank you.

P.T.O

This is 1 unit of alcohol… …and each of these is more than one unit



ALCOHOL SCREENING USING <u>FAST</u>

Questions	**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	
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	

If you have a **total score greater than 3** on the four questions above, you should go on to answer the six questions below.

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 Score (all 10 questions):

0 – 7 Lower risk,

8 – 15 Increasing risk,

16 – 19 Higher risk,

20+ Possible dependence