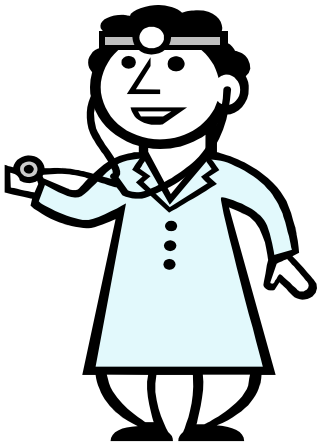
WHEATBRIDGE NEW PATIENT HEALTH QUESTIONNAIRE

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. [Note: It is recommended for all new patients to attend an assessment]



Surname: ..... Forename(s): .....

Date of Birth: ..... Marital status: .....

Address: .....

..... Postcode: .....

Home tel: ..... Mobile: .....

Email address: .....
Please indicate if we can contact you by text or e-mail (Yes) (No)
Can we contact you on behalf of the Patient Participation Group (Yes) (No)

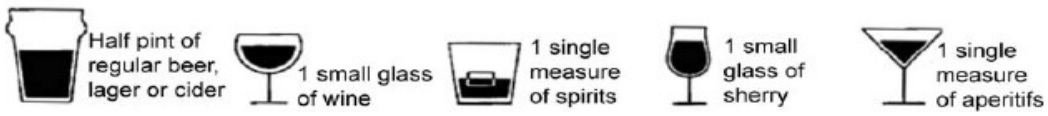
Occupation: ..... Ethnicity .....
Weight (approx): ..... Height: .....

I consent to the practice sending on my behalf, a Summary Care Record to the National Spine? **Yes / No**

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 much did you smoke per day? .....

Alcohol Consumption

This is one unit of alcohol...



...and each of these is more than one unit

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 - 9	10+	
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking. _____ Score
An overall total score of 5 or above is AUDIT-C positive.

DIET

Do you add salt to your food after cooking? Yes / No
Do you have a varied diet including milk, meat, vegetables and fruit? Yes / No
Has your Cholesterol been checked in the last 2 years? 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 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? …….
Site of cancer? ……

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: …… Name of drug: ……
Dosage: ……. Dosage: …….

Name of drug: ……
Dosage: …….

ALLERGIES

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

If yes, please give details:
……
……

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:
……

Please give details of any treatment for any chronic medical conditions:
……

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:
……

IMMUNISATIONS

Dates of Triple/polio/HIB: ……..
Dates of MMR: ……..
Date of last Tetanus: ……

FEMALE PATIENTS

Date of most recent cervical smear: ……..
Result of most recent smear: …….
Please give details of any complications in pregnancy:
……

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No
If "Yes", would you like them to deal with your health affairs here? Yes / No
(the receptionist can help with these arrangements)
Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

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