NEW PATIENT HEALTH QUESTIONNAIRE

Thank you for taking the time to fill in this questionnaire. The information you give will help us to make sure your medical records are up to date and will be recorded in your medical records

Please complete both sides of this form

Title:…….. Full Name: …… Date of Birth:.....

Address:……..Male/Female:…….....

Date form completed:.....

Your Height: ..... Your Weight:.....

Your occupation:.....

1. Smoking:

Have you ever smoked? **YES/NO**

Are you an ex-smoker **YES/NO** Date you stopped.....

If you are a current smoker How many cigarettes/day?... .....

Do you roll your own cigarettes? **YES/NO** If so, how much tobacco/week?.....

Are you a cigar smoker? **YES/NO** If so, how many/day ? ……..…….....

Do you smoke a pipe? **YES/NO** If so, how much tobacco/week?.....

2. Alcohol: Please circle the answer which best suits you

1 drink = ½ pint of beer/cider or 1 glass of wine or 1 single spirits

Men How often do you have eight or more drinks on one occasion?
Women How often do you have six or more drinks on one occasion?

Never Less than monthly Monthly Weekly Daily or almost daily

Please turn over and complete second page

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

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

Never Less than monthly Monthly Weekly Daily or almost daily

In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggest you cut down?

No Yes, but not in the last year Yes, during the last year

3. Family History

Has anyone in your family had a history of (please state relationship to you):-

Ischaemic Heart Disease under 60 YES/NO Family Member ….....

Ischaemic Heart Disease over 60 YES/NO Family Member ……....

CVA/stroke YES/NO Family Member ……...

Gastro Intestinal Problems YES/NO Family Member ……..…..…

Diabetes YES/NO Family Member .....

4. Do you have any disabilities, illnesses or accessibility needs? YES/NO

If yes, please tell us how we can help you to access our services: e.g. do you need help with communication/translation or to be accompanied by a person or assistance dog to each appointment.

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5. Are you a Carer? YES/NO

A carer is an unpaid person (although they may be in receipt of Carers' Allowance) who looks after a family member, friend or neighbour, who is elderly, disabled or ill and needs help to live at home. If yes, please give details below of the person for whom you care

Full Name: …… Date of Birth:……

Address:……