



**NEW PATIENT QUESTIONNAIRE**

**DATE:** .....

We need to collect some information about you and your family so that we can try to improve the Health Care we give you. It would help if you filled in this form.

Please ask if you need help with any of the questions.

SURNAME: ..... FORMER NAME: .....  
Mr/Mrs/Ms/Miss/Other (Please specify)

FIRST NAME(S): .....

OCCUPATION: ..... DATE OF BIRTH: .....

HOME TEL NO: ..... PERSONAL MOBILE TEL NO: .....

PERSONAL EMAIL ADDRESS: .....

ADDRESS: .....

.....  
POST CODE: ..... FIRST SPOKEN LANGUAGE: .....

***If you are an ex-member of the British Armed Services please state date of discharge*** .....

Please tell us where you heard about Priory Medical Group, i.e. Yellow Pages, friends, family, etc.

.....

**CARERS**

⇒ If you are a carer, please give details of who you care for

.....

.....

**FAMILY HISTORY**

⇒ Has any member of your close family (mother, father, sister, brother) had either of the following illnesses before the age of 60?

▪ Heart Attack

▪ Stroke

**YES**

**NO**

**ILLNESS**

⇒ Have you had any serious illnesses?

Please specify –

| Date | Illness |
|------|---------|
|      |         |
|      |         |
|      |         |
|      |         |

|                  | YES                      | NO                       |
|------------------|--------------------------|--------------------------|
| Is this ongoing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is this ongoing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is this ongoing? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is this ongoing? | <input type="checkbox"/> | <input type="checkbox"/> |

**MEDICATION** (including contraceptive pill and HRT)

⇒ Are you taking regular medication?

|     |                          |    |                          |
|-----|--------------------------|----|--------------------------|
| YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

Please specify –

| Current Drugs |
|---------------|
|               |
|               |
|               |

**SMOKING**

⇒ Do you smoke?

|     |                          |    |                          |
|-----|--------------------------|----|--------------------------|
| YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
|-----|--------------------------|----|--------------------------|

If "YES" please let us know the following:

- 1 – 9 cigarettes a day [ ]
- 10 – 19 cigarettes a day [ ]
- 20 – 30 cigarettes a day [ ]
- More than 30 cigarettes a day [ ]
- Cigar [ ]
- Pipe [ ]

If "NO" please let us know the following:

- Have you given up recently? [ ]
- Used to smoke ..... /day
- Never Smoked [ ]

**ALCOHOL**

If you are 16 years or over, please complete the attached questionnaire

**HEIGHT**

**CURRENT WEIGHT**

|                    |    |          |                   |    |           |
|--------------------|----|----------|-------------------|----|-----------|
| ..... ft ..... ins | OR | ..... cm | ..... st ..... lb | OR | ..... kgs |
|--------------------|----|----------|-------------------|----|-----------|



**ETHNICITY** – Department of Health instructions now require us to request the ethnicity of our patients.

I wish to state my ethnicity

Please specify Code .....  
(Please ask the receptionist for a list of Codes)




I do **NOT** wish to state my ethnicity

**Thank you for your help.**  
**Please return your completed questionnaire to the surgery as soon as possible**

Forename:

Surname:

Date:

|       |  |  |  |   |  |
|-------|--|--|--|---|--|
| UNITS | <br>2 | <br>1 | <br>9 | <br>2 | <br>1.5 |
|       | Glass of Wine<br>(175ml)   | Single Measure<br>of Spirits   | Bottle of<br>Wine  | Pint of Regular<br>Beer/Lager/Cider   | Alcopop or<br>Can of Lager   |

How many units per week do you drink  
Never drink alcohol

|  |
|--|
|  |
|  |

**AUDIT C**

| Questions  | Scoring System            |                           |                           |                           |                         | Your Score |
|--|---------------------------|---------------------------|---------------------------|---------------------------|-------------------------|------------|
|  | 0                         | 1                         | 2                         | 3                         | 4                       |            |
| How often do you have a drink that contains alcohol?                                   | Never                     | Monthly or less           | 2 – 4 times per month     | 2 - 3 times per week      | 4+ times per week       |            |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 – 2<br><i>(score 0)</i> | 3 – 4<br><i>(score 1)</i> | 5 – 6<br><i>(score 2)</i> | 7 – 9<br><i>(score 3)</i> | 10+<br><i>(score 4)</i> |            |
| How often do you have 6 or more standard drinks on one occasion?                       | Never                     | Less than monthly         | Monthly                   | Weekly                    | Daily or almost daily   |            |
| <b>TOTAL</b>   |                           |                           |                           |                           |                         |            |

**Scoring:** If your score is 5+ please complete the following questions -

**AUDIT**

| Questions   | Scoring System |                   |                               |        |                           | Your Score |
|---|----------------|-------------------|-------------------------------|--------|---------------------------|------------|
|   | 0              | 1                 | 2                             | 3      | 4                         |            |
| How often in the last year have you found you were not able to stop drinking once you had started?          | Never          | Less than monthly | Monthly                       | Weekly | Daily or almost daily     |            |
| How often in the last year have you failed to do what was expected of you because of drinking?              | Never          | Less than monthly | Monthly                       | Weekly | Daily or almost daily     |            |
| How often in the last year have you needed an alcoholic drink in the morning to get you going?              | Never          | Less than monthly | Monthly                       | Weekly | Daily or almost daily     |            |
| How often in the last year have you had a feeling of guilt or regret after drinking?                        | Never          | Less than monthly | Monthly                       | Weekly | Daily or almost daily     |            |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never          | Less than monthly | Monthly                       | Weekly | Daily or almost daily     |            |
| Have you or someone 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/friend/doctor/health worker been concerned about your drinking or advised you to cut down?   | No             |                   | Yes, but not in the last year |        | Yes, during the last year |            |
| <b>TOTAL (inc Audit C total)</b>  |                |                   |                               |        |                           |            |

**Depending on your score, you may be offered an appointment with the Doctor**