Today's Date:…………………….. **Petersfield Medical Practice**

NEW PATIENT QUESTIONNAIRE

Full Name		Title	
Emergency Contact			
1st Language			
Occupation			
Height		Date of Birth	
Weight		Sex	Male ☐ Female ☐

Ethnic Group (please tick)

White:	Mixed:	Black or Black British:
☐ British	☐ White and Black Caribbean	☐ Caribbean
☐ Irish	☐ White and Black African	☐ African
☐ Other (please specify)………………………	☐ White and Asian	☐ Other (please specify)
	☐ Other (please specify)………… ……………	………………………………
Asian or Asian British:	Chinese:	Other Ethnic Group:
☐ Indian	☐ Chinese	☐ Please specify:
☐ Pakistani	☐ Other (please specify)………………………	………………………………
☐ Bangladeshi		☐ Do not wish to disclose
☐ Other (please specify)………………………		

Smoking

Do you smoke?	
	☐ Never smoked ☐ Light Ex-smoker ☐ Moderate Ex-smoker ☐ Heavy Ex-smoker If ex-smoker, when did you stop smoking?………………………………… ☐ Yes How much do you smoke per day? …………………………………………… Would you like to receive stop smoking advice? ……………………………………………

Alcohol

Tick the boxes that apply to you and add up the points to find your total.

Question	Answer
How often do you have a drink that contains alcohol?	☐ Never *(0 points)* ☐ Monthly or less *(1 point)* ☐ 2 – 4 times per month *(2 points)* ☐ 2 – 4 times per week *(3 points)* ☐ 4 + times per week *(4 points)*
How many standard alcoholic drinks do you have on a typical day when you are drinking?	☐ 1 – 2 *(0 points)* ☐ 3 – 4 *(1 point)* ☐ 5 – 6 *(2 points)* ☐ 7 – 9 *(3 points)* ☐ 10 + *(4 points)*
How often do you have 6 or more standard drinks on one occasion?	☐ Never *(0 points)* ☐ Monthly or less *(1 point)* ☐ 2 – 4 times per month *(2 points)* ☐ 2 – 4 times per week *(3 points)* ☐ 4 + times per week *(4 points)*
Total Score*	……………………….. points

***If you score 5 or more, please complete the questionnaire over the page**

Do you (or an immediate member of your family) suffer from any of the following conditions?

	Yes	No	Family Member (please specify)
Asthma			
Diabetes			
Heart Disease			
Stroke / Mini Stroke / Transient Ischaemic Attack (TIA)			
Any other serious illness / problem (please specify): …………………………………… ……………………………………			

Please list any repeat medication you are taking:*

Please list any allergies you have:

**If you are prescribed the oral contraceptive pill, you should make an appointment with the practice nurse for a pill-check before your next prescription is due.*

Today's Date:……………………..

NEW PATIENT QUESTIONNAIRE

AUDIT

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	
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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence