Chapelgreen Practice

New Patient Questionnaire

FOR PRACTICE USE ONLY

Patient Identification checked Yes ☐ No ☐

Document provided: Passport ☐ Driving License ☐ Birth certificate ☐

Other : Please specify below

Verified by:----------

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1. **Have you been registered with this practice before?**
   YES ☐ NO ☐

2. Complete the following demographic questions.	
Salutation (Mr, Mrs, Ms, Miss)	
Surname	
Forename	
Date of Birth	
Home Address	
Telephone Numbers	Home: Mobile:
Marital Status	
Place of Birth	

Ethnic Origin (Please tick one box)				
British or mixed British		Caribbean	
Irish		Pakistani or British Pakistani	
Other White Background		Bangladeshi or British Bangladeshi	
White and Black Caribbean		Other Asian Background	
White and Black African		African	
White and Asian		Other black background	
Other Mixed Background		Chinese	
Indian or British Indian		Other (Please State) _____	

3. The following are some lifestyle/medical questions. Please answer all where possible.

What is your alcohol consumption per week? Units per week
(1 Unit = Glass of wine, 1 measure of spirits, half pint of beer)

How much exercise do you get each week?
(None, Light, Moderate, Heavy, Not possible)

What is your smoking status?
(i.e.Smoker, Never smoked, Ex Smoker)

If yes, how many a day?

If you smoke, would you be interested in stopping? YES NO

What is your Height and Weight? Height Weight

Have you had any vaccines in the last year?
If so, which? Please leave blank if none.
(Hepatitis B, Travel Vaccines, Typhoid)

This section is to be completed by WOMEN only.	
Have you ever been pregnant?	
When did you last have a smear test?	
Are you using contraception? (If yes, what form of contraception are you using?)	

Have you had any of the following medical problems?

	YES		YES
Arthritis		Asthma	
Cancer		Chronic Bronchitis/ COPD	
Depression		Diabetes	
Epilepsy		High Blood Pressure	
Thyroid		Ulcer (Duodenal/Gastric)	
Stroke		Tuberculosis	
Heart Attack/ Angina			

Are you registered disabled? YES ☐ NO ☐

if yes, what is the nature of your disability? _____
_____
_____

Are you a carer? YES ☐ NO ☐

I am a…			
Carer of a person with learning disability		Carer of a person with chronic disease	
Carer of a person with a physical disability		Carer of a person with mental health problems	
Carer of a person with sensory impairment		Carer of a person with a terminal illness	
Carer of a person with a substance misuse		Other _____	

This section is to be completed for CHILDREN only.	
Have had all immunisations before starting school?	
Had a tetanus/polio injection before leaving school?	
Received any other vaccines?	

4. Consenting to share information

By consenting to share information it will give Community NHS Services that could provide care for you access to your medical record.

If you were to give your consent then any NHS clinical member of staff can only do so under the following conditions

- They must be involved in caring for you or have been involved in the past and has a justifiable need to review your record.
- Must have an NHS smartcard, which controls access to information.
- Will have their details recorded – who they are and if they added or changed any of your information

By consenting you can still request that part of your record, like a particular consultation with your GP, is not shared.

☐ I **AGREE** to you providing access to my health information for other health professions involved in my care

☐ I **DO NOT AGREE** to you providing access to my health information for other health professions involved in my care

5. Connecting to your practice

Chapelgreen Practice

At Chapelgreen Practice we're always looking for new ways to make contacting us and getting the service you require faster.

Mobile Contact and SMS Messaging

In the future, with your consent, we will now be able to send you a free SMS text message of your appointment bookings. To opt into this service please agree to us contacting you via SMS messaging about your future appointments.

☐ I **AGREE** to contact via SMS messaging

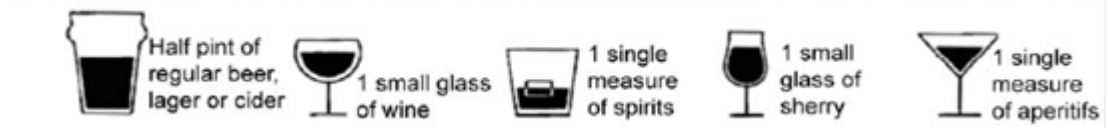
☐ I **DO NOT AGREE** to contact via SMS messaging

Email Contact

For services currently in development we may also be able to contact you via email. If you agree to us contacting you via email then please supply your email address below

Email: _____

This is one unit of alcohol…



…and each of these is more than one unit

Name:_____ DOB:_____

AUDIT – C

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	

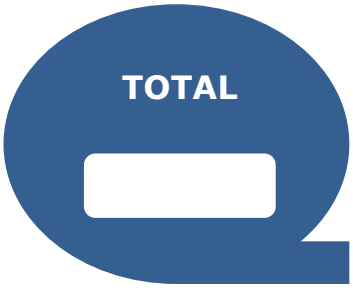
Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	4	
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



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions