PENISTONE GROUP PRACTICE

NEW PATIENT HEALTH QUESTIONNAIRE

Your Contact Details:-

Title (Mr/Mrs etc)		Surname	
Date of Birth		First Names	
Occupation		Previous Surnames	
Home Address Postcode		Home Tel **Mobile** **Email Address**	

Do you require online access to order medications/view medical records **YES/NO**
If YES please provide a form of ID e.g Passport/Driving License

Have you served in the British Armed Forces?	YES/NO
Do you have any specific communication needs?	YES/NO

Information About You:-

Height		First language	
Weight		Ethnic Status	

Next of kin (please give name, Address, Telephone Number & Relationship)

Are you a Carer?	YES/NO	Do you ***have*** a Carer?	YES/NO
If Yes, please give details		If Yes, please give details	

Significant Medical Conditions:-

Current Medication:-

Family History:-	Heart Attack	YES/NO		Asthma	YES/NO
	Diabetes	YES/NO		Stroke	YES/NO

Have you had any recent unintentional weight loss? YES/NO

If YES how much?

Over what period of time?

PTO

Exercise per week:-	1	2	3	4
	Please circle as appropriate (20 minutes of exercise = 1 session)			

Do you Smoke? YES/NO If No, have you ever smoked? YES/NO

If you do currently smoke,
how many cigarettes or ounces of tobacco do you smoke per day

Would you like advice on giving up smoking? YES/NO

ALCOHOL SCREENING

Questions	Scoring System 0	1	2	3	4	Your Score
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	3-4	5-6	7-9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
				TOTAL OF 3 QUESTIONS ABOVE		
Please complete the questions below ONLY if you have a score of 5 or more						
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	

ALCOHOL CONSUMPTION

Units per week

(1 unit = 1 glass wine/half pint beer/1 measure spirits)