**Culloden Surgery**

**New Patient Questionnaire**

|  |  |
| --- | --- |
| Full Name: | Date of Birth: |
| Address:Postcode: | Landline:Mobile:Work: |
| Occupation: | Relationship Status: |
| Next of kin: Relationship to you:Contact number: |
| Ethnic Origin:White: British [ ]  Irish [ ]  Scottish [ ]  Any other white background (please state): Asian or Asian British: Bangladeshi [ ]  Chinese [ ]  Indian [ ]  Pakistani [ ] Any other Asian background (please state): Black or Black British: African [ ]  Caribbean [ ]  Other (please state) Any other black background (please state): Mixed: White & Black African [ ]  White & Black Caribbean [ ]  White & Asian [ ]  Any other mixed background (please state): Other ethnic group (please state): Declined [ ]  |

**CURRENT MEDICATION & ALLERGIES**

**Do you have any allergies?** Yes [ ]  please give details

 No [ ]

**Please list any medication you are currently taking in the box below. If you have a medication list from your previous practice please attach it or send it alongside this form.**

|  |  |
| --- | --- |
| **Name and strength of prescribed medication** | **Dose** |
|  |  |

**EXERCISE & LIFESTYLE**

**Which of the following statements about exercise applies best to you?**

Exercise physically impossible [ ]  Avoids even trivial exercise [ ]  Enjoys light exercise [ ]

Enjoys moderate exercise [ ]  Enjoys heavy exercise [ ]  Competitive athlete [ ]

**Do you smoke?**

I am a smoker [ ]  I have never smoked [ ]  I am an ex-smoker [ ]  date gave up

*How many do you smoke a day How many did you smoke a day*

**How many units of alcohol do you consume in an average week?**

*1 unit = half a pint of lager, half a small glass of wine or one measure of spirits*

Number of units None, I am a lifelong teetotaler [ ]  None, I stopped drinking on (date)

**If you drink alcohol then please answer the following questions and add up your score (see the scores for each answer in brackets):**

|  |
| --- |
| **How often do you have six (for women) or eight (for men) standard drinks on one occasion?***Never(0)* [ ]  *Less than monthly(1)* [ ]  *Monthly(2)* [ ]  *Weekly(3)* [ ]  *Daily/almost daily(4)* [ ]  |
| **How often in the last year have you failed to do what was expected of you due to drinking?***Never(0)* [ ]  *Less than monthly(1)* [ ]  *Monthly(2)* [ ]  *Weekly(3)* [ ]  *Daily/almost daily(4)* [ ]  |
| **How often in the last year have you not been able to remember what happened the night before because you had been drinking?***Never(0)* [ ]  *Less than monthly(1)* [ ]  *Monthly(2)* [ ]  *Weekly(3)* [ ]  *Daily/almost daily(4)* [ ]  |
| **In the last year has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?***Never(0)* [ ]  *Yes, on one occasion(2)* [ ]  *Yes, on more than one occasion(4)* [ ]  |
| **Total score:** *If your total is 3 or more then we recommend that you visit* [*www.nhs.uk/better-health/drink-less*](http://www.nhs.uk/better-health/drink-less) *for advice on safe alcohol consumption.* |

**YOUR MEDICAL HISTORY**

|  |  |
| --- | --- |
| **Have you ever suffered from** | **Details** |
| Heart disease Yes [ ]  No [ ]  |  |
| Stroke or TIA Yes [ ]  No [ ]  |  |
| Diabetes Yes [ ]  No [ ]  |  |
| High blood pressure Yes [ ]  No [ ]  |  |
| Hypothyroidism Yes [ ]  No [ ]  |  |
| Asthma Yes [ ]  No [ ]  |  |
| COPD Yes [ ]  No [ ]  |  |
| Epilepsy Yes [ ]  No [ ]  |  |
| Mental illness Yes [ ]  No [ ]  |  |
| HIV Yes [ ]  No [ ]  |  |
| Other (please provide details) |  |

|  |
| --- |
| Do you have a carer?Yes [ ]  No [ ] Details if yes: |
| Are you a carer? Yes [ ]  No [ ]  Details if yes: |

**FAMILY MEDICAL HISTORY (parents, brothers and sisters)**

|  |  |
| --- | --- |
| **Have your parents or siblings ever suffered from** | **Details** |
| Heart disease Yes [ ]  No [ ]  *If yes were they:* *over 60* [ ]  *under 60* [ ]  |  |
| Stroke or TIA Yes [ ]  No [ ]  |  |
| Diabetes Yes [ ]  No [ ]  |  |
| High blood pressure Yes [ ]  No [ ]  |  |
| Breast cancer Yes [ ]  No [ ]  |  |
| Ovarian cancer Yes [ ]  No [ ]  |  |
| Bowel cancer Yes [ ]  No [ ]  |  |
| Other (please provide details) |  |