**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) |  |