NEW PATIENT HEALTH QUESTIONNAIRE
PLEASE COMPLETE ALL PAGES

Information about you

Title		Surname	
Previous Surname(s)		First names	
Calling Name:		Date of Birth	
Email:		What is your first language?	
Telephone Number:		Mobile Number:	
What is your height?		What is your weight?	

Would you like to book appointments online?	O Yes O No
Would you like to order your prescriptions online?	O Yes O No

Do you need assistance accessing our services?	O Yes O No
If yes – Do you require a language translator including BSL	O Yes O No
If yes - Do you have an assistance dog e.g. guide dog, hearing dog etc	O Yes O No
If yes – Do you use a walking aid or mobility scooter?	O Yes O No
If you have a disability, impairment or sensory loss:	
Do you need information in a different format to a standard letter? If Yes - Please complete an Accessible Information Form	O Yes O No
Do you need any communication support? If Yes - Please complete an Accessible Information Form	O Yes O No

Ethnic Group

White	O British	O Irish	O Other	If other please specify	
Black	O Caribbean	O African	O Other	If other please specify	
Asian	O Indian	O Pakistani	O Chinese	O Other	If other please specify
Mixed	O White + Black Caribbean	O White + Black African	O White + Asian		
Other	O Other	If other please specify			

Some of the information on this form may be used as part of your Shared Care Record, if you would like more information about your Shared Care Record or to opt out please ask the Receptionist

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Smoking

Do you smoke? O Yes O No	If 'No', have you ever smoked? O Yes O No How many per day?
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? O Yes O No	

Carer

Do you have a Carer?	O Yes* O No
Are you a Carer?	O Yes* O No
* If you have answered Yes to any of the above questions, please ask for a Carer's Pack. The Carer's pack contains further information for you about support available to you and an additional information form that we ask you to complete.	

Military – Serving / Veteran or Dependant

Are you currently serving in the British Armed Forces?		O Yes O No
Are you a Military Veteran of the British Armed Forces?		O Yes O No
If you are / have served in British Armed Forces, please indicate which service. (For Reservists please also indicate which service)	O Royal Navy / Royal Marine O British Army O Royal Air Force O Reservist	
Have you deployed on operations e.g. OP TELIC / HERRICK etc? (For Reservists/Territorial Army please confirm if you have served as Regular service personnel for more than one day)		O Yes O No
Are you a: Dependant of a current serving member of the British Armed Forces? Dependant of a former serving member of the British Armed Forces?		 O Yes O No O Yes O No

Next of Kin

Please give name, address and telephone number of next of kin
Relationship to you:
Emergency Contact: O Yes O No If Yes - Please provide their telephone / mobile number:
Permission to disclose Medical Information O Yes O No

Please sign and date below:

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Signed_____ Date _____

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NEW PATIENT HEALTH QUESTIONNAIRE

Alcohol

Questions	Scoring system					Your score
	0	1	2	3	4	
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 been unable to remember what happened the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
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	

Scoring:

A total of 3+ may indicate hazardous or harmful drinking

If you score 3 or more, please fill in the more detailed questionnaire at the end of this questionnaire

NEW PATIENT HEALTH QUESTIONNAIRE

Alcohol Users Disorders Identification Test (AUDIT)

Questions	Scoring system					Your Score
	0	1	2	3	4	
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 – 8	10 +	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 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 or 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	

Scoring: 0-7 = Sensible Drinking, 8-15 = hazardous drinking, 16-19 harmful drinking and 20+ = possible dependence