**NEW PATIENT QUESTIONNAIRE** (STRICTLY CONFIDENTIAL)

 Name........................................................ Tel. No..............................……... Today's Date.........................

 Date of Birth..............................……….. Weight ..................................... Height.................................….

 Do you smoke? Yes No If YES how many per day?..............................................…..

 Have you ever smoked? Yes No If YES how many per day?………………………………………………………

 at what age did you start?…………………………………………

 at what age did you stop?………………………………………….

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4+times per week |
| **Please tick** |  |  |  |  |  |
| How many units of alcoholic drink do you have on a typical day when you are drinking? (See below) | 1-2 units | 3-4 units | 5-6 units | 7-8 units | 10+ units |
| **Please tick** |  |  |  |  |  |
| How often do you have 6 or more units on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **Please tick** |  |  |  |  |  |

Pint of regular beer/lager/cider = 2 units Single measure of spirits = 1 unit

Glass of wine (175ml) = 2 units Alcopop or can of lager = 1.5 units

Bottle of wine = 9 units

 Please indicate which sentence applies to you and only count exercise that makes your heart race

 I don't take any exercise I take light exercise I take moderate exercise

 I exercise a great deal I am an athlete Exercise is impossible for me

 Do you eat a varied diet? Yes No If NO please give details (e.g. vegetarian)..........................

 Do you consider your salt intake to be Low Medium High

 Do you suffer from, or been treated for any of the following?

 Asthma Heart problems Diabetes Cancer

 Stroke Epilepsy TB Depression/mental illness

 Glaucoma High cholesterol High Blood Pressure Jaundice

 Any other major illness.......................................................

 Have any near relatives suffered from heart disease? Yes No

 If YES please give age and relationship ……………………………………………………………………………………………………..

 Have any near relatives suffered from any of the following?

 Stroke Diabetes Asthma High Blood Pressure Cancer

 Any other major illness?................................................... Family History Unknown

 Are you a Carer for a sick, disabled or elderly relative or friend? Yes No

 Have you had any surgical operations? Yes No If YES please state.................................................

 Are you allergic to any drugs?.......................... Are you allergic to anything else?...................................

Do you have any communication needs? ……………………………………………………………………………………………………………………………………………………………………………………………………………………….…

 Do you need a format other than standard print? ………………………………………………………………………………………………………………………………………………………………………………………………………………………….

 Do you have any special communication requirements? ……………………………………………………………………………………………………………………………………………………………………………………………………………………….…

 Can you explain what support would be helpful? ………………………………………………………………………………………………………………………………………………………………………………………………………………………….

 What communication support could we provide for you? ………………………………………………………………………………………………………………………………………………………………………………………………………………………….

 ………………………. Continued overleaf .......

 LADIES ONLY

 Has your Mother or Sister suffered from breast cancer? Yes No

 Are you pregnant? Yes No

 Which type of contraception do you use if any?................................................…………………

 What was the date and result of your last smear test?......................................…………….

 Please indicate your ethnic category

 British or mixed British  Pakistani 

 Other White background  Bangladeshi 

 Irish  Other Asian background 

 White & Black African  Other Black background 

 White & Black Caribbean  Indian 

 White & Asian  Chinese 

 Other Mixed background  Other 

PLEASE COMPLETE STATEMENT BELOW

The practice may need to contact you at any time. The practice preferred method of contact is by letter, please tick

To confirm this is your preference - 

Any Comments ………………………………………………………………………………………………………………………………..