



The Blue Practice

NEW PATIENT QUESTIONNAIRE



We would appreciate as a newly registered patient of our Practice you complete and return this questionnaire. As a new patient you may be asked to attend for a New Patient Medical check to discuss your health needs. The Practice will inform you if you need to make an appointment.

Date:

Title: MR / MRS / MISS / MS if other please state **Marital Status:**

Surname: **First Name:**

D.O.B:

Telephone Number: (Home) **(Mobile)**

Occupation:

Ethnic Origin: e.g White, Asian, Black other

Current Medical Problems:

Current Medication with dose and frequency:

Do you buy any medication regularly from the Pharmacy? E.g. Aspirin



Past Medical History or Operations including dates (Please include any pregnancies if applicable): ...

Known Food Allergies/Special Diets:

Known Drug Allergies:

***** PLEASE ANSWER THE QUESTIONS ON THE REVERSE SIDE – THANK YOU *****

Personal/Family History:



Ischaemic Heart Disease	Yes / No	Relation to you:
Hypertension	Yes / No	Relation to you:
Stroke	Yes / No	Relation to you:
Asthma	Yes / No	Relation to you:
Cancer	Yes / No	Relation to you:
Diabetes	Yes / No	Relation to you:
Glaucoma	Yes / No	Relation to you:
Osteoporosis	Yes / No	Relation to you:

***Carers:**

Are you a carer? Yes / No

If YES please state name, address and telephone number for whom you care for:

Do you have a carer? Yes / No

If YES please state name, address and telephone number of your carer:

* A carer is someone who, without payment, provides help and support to a partner, relative, friend or neighbour who could not manage without your help. This could be due to their age, physical or mental illness, addiction or disability.

Smoking:

Do you smoke? (please circle appropriate one)

Never Smoked

Current Smoker I currently smoke per day

Ex-Smoker I used to smoke per day and stopped in

For woman only:

Have you had a cervical smear? Yes / No

Date of last smear: Place smear was carried out:

***** Please note if the attached Registration Form (GPR) is NOT fully completed
it may delay your registration *****

Thank you for completing this questionnaire

BLUE PRACTICE CRIEFF MEDICAL CENTRE LIFESTYLE QUESTIONNAIRE

We are currently collecting lifestyle information on our patients. It would help if you could please complete this questionnaire before your appointment and hand it to your GP or Practice Nurse. Thank you in anticipation for your co-operation with this.

Title: Mr/Mrs/Miss/Ms First names: Surname:

Date of birth:

SMOKING

Do you smoke: **Yes** **No**

If yes how many per day:

If yes would you like help to stop:

The Practice Nurse runs a smoking cessation clinic please make an appointment for advice on stopping smoking.

If no have you ever smoked:

If yes how many and when did you stop:

ALCOHOL

For the following questions please tick the answer which best applies
1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirit

	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
MEN: How often do you have EIGHT or more drinks on one occasion?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
WOMEN: How often do you have SIX or more drinks on one occasion?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do what was normally expected of you because of drinking?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

	No	Yes, on one occasion	Yes, on more than one occasion
In the last year has a relative or friend Or a doctor or other health worker been Concerned about your drinking or Suggested you cut down?	<input type="checkbox"/> 0	<input type="checkbox"/> 2	<input type="checkbox"/> 4

Total for each column:

TOTAL

IF YOU SCORE 3 OR MORE PLEASE TURN OVER AND COMPLETE THE 2nd SET OF QUESTIONS
2nd SET OF QUESTIONS

1. How often do you have a drink containing alcohol?	Never <input type="checkbox"/> 0	Monthly or less <input type="checkbox"/> 1	2 - 4 times a month <input type="checkbox"/> 2	2 - 3 times a week <input type="checkbox"/> 3	4 or more times a week <input type="checkbox"/> 4
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2 <input type="checkbox"/> 0	3 or 4 <input type="checkbox"/> 1	5 or 6 <input type="checkbox"/> 2	7 to 9 <input type="checkbox"/> 3	10 or more <input type="checkbox"/> 4
3. How often do you have eight (for men) or six (for women) or more units on one occasion?	Never <input type="checkbox"/> 0	Less than monthly <input type="checkbox"/> 1	Monthly <input type="checkbox"/> 2	Weekly <input type="checkbox"/> 3	Daily or almost daily <input type="checkbox"/> 4
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never <input type="checkbox"/> 0	Less than monthly <input type="checkbox"/> 1	Monthly <input type="checkbox"/> 2	Weekly <input type="checkbox"/> 3	Daily or almost daily <input type="checkbox"/> 4
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never <input type="checkbox"/> 0	Less than monthly <input type="checkbox"/> 1	Monthly <input type="checkbox"/> 2	Weekly <input type="checkbox"/> 3	Daily or almost daily <input type="checkbox"/> 4
6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never <input type="checkbox"/> 0	Less than monthly <input type="checkbox"/> 1	Monthly <input type="checkbox"/> 2	Weekly <input type="checkbox"/> 3	Daily or almost daily <input type="checkbox"/> 4
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never <input type="checkbox"/> 0	Less than monthly <input type="checkbox"/> 1	Monthly <input type="checkbox"/> 2	Weekly <input type="checkbox"/> 3	Daily or almost daily <input type="checkbox"/> 4
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never <input type="checkbox"/> 0	Less than monthly <input type="checkbox"/> 1	Monthly <input type="checkbox"/> 2	Weekly <input type="checkbox"/> 3	Daily or almost daily <input type="checkbox"/> 4
9. Have you or someone else been injured as a result of drinking?	No		Yes, but not in the last year	Yes, during the last year	
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year	Yes, during the last year	
Total for each column:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL	<input type="text"/>				
Brief Intervention Booklet Given	<input type="checkbox"/>	G.P./PN			
		Date.....			