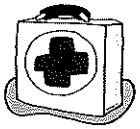

The Blue Practice

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 = ½ 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? WOMEN: How often do you have SIX or more drinks on one occasion?	☐0	☐1	☐2	☐3	☐4
	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 because you had been drinking?	☐0	☐1	☐2	☐3	☐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?	☐0	☐1	☐2	☐3	☐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?	☐0	☐2	☐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** ☐0	**Monthly or less** ☐1	**2 – 4 times a month** ☐2	**2 – 3 times a week** ☐3	**4 or more times a week** ☐4
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	**1 or 2** ☐0	**3 or 4** ☐1	**5 or 6** ☐2	**7 to 9** ☐3	**10 or more** ☐4
3. How often do you have eight (for men) or six (for women) or more units on one occasion?	**Never** ☐0	**Less than monthly** ☐1	**Monthly** ☐2	**Weekly** ☐3	**Daily or almost daily** ☐4
4. How often during the last year have you found that you were not able to stop drinking once you had started?	**Never** ☐0	**Less than monthly** ☐1	**Monthly** ☐2	**Weekly** ☐3	**Daily or almost daily** ☐4
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	**Never** ☐0	**Less than monthly** ☐1	**Monthly** ☐2	**Weekly** ☐3	**Daily or almost daily** ☐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** ☐0	**Less than monthly** ☐1	**Monthly** ☐2	**Weekly** ☐3	**Daily or almost daily** ☐4
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	**Never** ☐0	**Less than monthly** ☐1	**Monthly** ☐2	**Weekly** ☐3	**Daily or almost daily** ☐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** ☐0	**Less than monthly** ☐1	**Monthly** ☐2	**Weekly** ☐3	**Daily or almost daily** ☐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:	☐	☐	☐	☐	☐
TOTAL			☐		

Brief Intervention Booklet Given ☐ **G.P./PN** .....**Date**.....