

# Dapdune House Surgery

## New Patient Questionnaire

Please complete as many questions as you can. You are under no obligation to complete this form but your medical records may take several months to reach us, and the information you give us will assist us in providing you with good medical care.

**Any information you give is confidential.**

### *Registration Details*

***Previous registration with this practice for you or any of your family members***

Have you been registered with this practice before?      Yes       No

If so, was this as      Permanent Registration       Temporary Resident

Is anyone else in your household registered with this practice?      Yes       No

If so, please state name(s)

### *Your personal details*

**Title**      Mr.       Mrs.       Miss       Ms.       Dr.       Rev.       Other

**Names**      Surname

Previous Surname (if applicable)

Forename(s)

Usual Forename

**Marital Status**      Single       Cohabiting       Married       Separated       Divorced       Widowed

**Date of Birth**       **Occupation**

**Place of Birth**

	<b>Current Address (including Postcode)</b>
	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>
<b>Telephone (Home)</b>	<input style="width: 100%;" type="text"/>
<b>Telephone (Mobile)</b>	<input style="width: 100%;" type="text"/>

<b>Previous Address (including Postcode)</b>
<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>
<input style="width: 100%;" type="text"/>

	<b>Next of Kin</b>
<b>Name</b>	<input style="width: 100%;" type="text"/>
<b>Address</b>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>
<b>Telephone (Home)</b>	<input style="width: 100%;" type="text"/>
<b>Relationship to Patient</b>	<input style="width: 100%;" type="text"/>

## Ethnic Group

White		Mixed		Asian or Black Asian	
A	<input type="checkbox"/> British	D	<input type="checkbox"/> White & Black Caribbean	H	<input type="checkbox"/> Indian
B	<input type="checkbox"/> Irish	E	<input type="checkbox"/> White & Black African	I	<input type="checkbox"/> Pakistani
C	<input type="checkbox"/> Other white background	F	<input type="checkbox"/> White & Asian	J	<input type="checkbox"/> Bangladeshi
		G	<input type="checkbox"/> Other mixed background	K	<input type="checkbox"/> Other Asian background
<b>Black or Black British</b>		<b>Other Ethnic Categories</b>			
L	<input type="checkbox"/> Caribbean	O	<input type="checkbox"/> Chinese		
M	<input type="checkbox"/> African	P	Any other Ethnic category – please state below:		
N	<input type="checkbox"/> Other black background	<input type="text"/>			

## Lifestyle

### Tobacco consumption

Never Smoked	<input type="checkbox"/>	Pipe Smoker	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	Ex-Smoker	<input type="checkbox"/>
		Oz per day	<input type="text"/>			Year Stopped	<input type="text"/>
				Less than 1 a day	<input type="checkbox"/>	Less than 1 a day	<input type="checkbox"/>
				1-9 a day	<input type="checkbox"/>	1-9 a day	<input type="checkbox"/>
				10-19 a day	<input type="checkbox"/>	10-19 a day	<input type="checkbox"/>
				20-39 a day	<input type="checkbox"/>	20-39 a day	<input type="checkbox"/>
				More than 40 a day	<input type="checkbox"/>	More than 40 a day	<input type="checkbox"/>

**Free NHS Stop Smoking Service on 0845 602 3608 or ask @ Dapdune Pharmacy**

### Body Mass

Height	<input type="text"/>	Weight	<input type="text"/>	Waist circumference	<input type="text"/>
--------	----------------------	--------	----------------------	---------------------	----------------------

### Alcohol consumption

Nil	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	1-7 Units a week	<input type="checkbox"/>	8-14 Units a week	<input type="checkbox"/>
		15-21 Units a week	<input type="checkbox"/>	22-35 Units a week	<input type="checkbox"/>	36-49 Units a week	<input type="checkbox"/>
						More than 50 Units a week	<input type="checkbox"/>

**One unit = ½ pint of beer/lager, 1 shot measure of spirits, 1 small glass of wine**

### Exercise

Exercise impossible	<input type="checkbox"/>	Light exercise	<input type="checkbox"/>	Moderate exercise	<input type="checkbox"/>	Vigorous exercise	<input type="checkbox"/>
---------------------	--------------------------	----------------	--------------------------	-------------------	--------------------------	-------------------	--------------------------

In what form?

## Disabilities

Are you housebound?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from severe hearing loss?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you Registered Blind?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from learning disabilities?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Do you have a carer?

Yes

No

*If Yes, please complete*

**Details of Carer**

Name

Address

Telephone

Relationship to Patient (if any)

Are you a carer for someone?

Yes

No

*If Yes, please complete*

**Details of Person you care for**

Name

Address

Telephone

Relationship to Patient (if any)

Why do you care for them?

***Family History***

	State present health and serious illness suffered	If deceased Age at death	Cause of death
<b>Father</b>			
<b>Mother</b>			

Please tick if **your parents** have suffered from any of the following:

**Father** Heart Attack/ Angina  High BP  Stroke  Asthma  Diabetes  Cancer

**Mother** Heart Attack/ Angina  High BP  Stroke  Asthma  Diabetes  Cancer

Have any brothers/sisters died/suffered from serious illness? Yes  No

Please state details

***Your Health***

Please tick if **you** have suffered, or are suffering, from any of the following:

Epilepsy  Heart Attack/ Angina  High BP  Stroke  Asthma  Diabetes  Cancer

***Other illnesses, Operations & Accidents***

Year	Details

Have you ever suffered any severe mental/nervous problems? Yes  No

Please state details

## *Prescribed Drugs and Medicines*

Please state below any medicines (including the contraceptive pill) **prescribed for you** by your GP

Name and strength of medicine	How often taken	Date started

## *Over the Counter Drugs and Medicines*

Please state below any medicines you **buy for yourself**

Name and strength of medicine	How often taken	Date started

Have any had any allergies (to drugs or other materials)?      Yes       No

Please state details

How severe?

## *Adult Immunisations*

Please complete if the patient is **over 16**

<b>Injection</b>	<b>Y</b>	<b>N</b>		<b>Year</b>	<b>Month</b>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	When given	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>

## *For Women Only*

	<b>Y</b>	<b>N</b>		<b>Year</b>	<b>Month</b>
Have you had the Rubella jab?	<input type="checkbox"/>	<input type="checkbox"/>	When given	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>		<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
Have you had a mammogram?	<input type="checkbox"/>	<input type="checkbox"/>		<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
Have you had a cervical smear?	<input type="checkbox"/>	<input type="checkbox"/>		<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>
Was it abnormal?	<input type="checkbox"/>	<input type="checkbox"/>			

If Yes, please give details

**Please give the dates of any pregnancies, as shown below**

Normal births	Caesarians	Miscarriages	Terminations

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**The Alcohol Use Disorder Identification Test: Self-Report Version**

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments. It is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place a 'X' (cross) in one box that best describes your answer to each question.

<b>Questions</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about the drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					<b>Total</b>	

**Please fill in this questionnaire if you are 16 years or older.**