BRUNTON PARK HEALTH CENTRE
NEW PATIENT QUESTIONNAIRE

Title:	_____	**Name:**	_____	**DOB:**	_____
Address:	_____			**Tel:**	_____
	_____			**Mob:**	_____
Occupation:	_____			**Email:**	_____

Next of Kin: (name, address and contact number)

Relationship of Next of Kin:

Do you smoke?	**Yes**	☐	**No**	☐	If yes how many per day?	_____
Have you ever smoked?	**Yes**	☐	**No**	☐	If yes when did you stop?	_____
There is a smoking cessation service at Bank's Pharmacy, Brunton Park for patients needing help to stop smoking.						
Do you drink alcohol?	**Yes**	☐	**No**	☐	If yes how many units per week?	_____
(1 Unit = Half Pint Beer/Lager, 1 Glass of Wine or 1 Pub Measure of Spirits)						

Do you have any ongoing medical conditions or have you had any serious illnesses or operations? Please specify			**Yes** ☐ **No** ☐
_____	_____	_____	_____

Are you on any medication? please list			
Name	Strength	Dose	Days/Quantity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALL PRESCRIPTIONS ARE SENT ELECTRONICALLY TO A PHARMACY. PLEASE PROVIDE THE NAME AND ADDRESS OF THE PHARMACY OF YOUR CHOICE: .....
.....

What is your height? _____	What is your current weight? _____

Have you had your blood pressure checked recently? If so do you know what it was?	
BP _____	Date taken _____

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Do you regularly perform any physically strenuous activities, e.g. sports, gardening cycling etc **Yes** ☐ **No** ☐

Are you allergic to anything? **Yes** ☐ **No** ☐ If yes what? _____

For women when was your last cervical smear? _____

Do you take an oral contraceptive pill? **Yes** ☐ **No** ☐			
if yes, which one			
Name	Strength	Dose	Days/Quantity
_____	_____	_____	_____

Do you have any close family members who suffer from any of the following illnesses?								
Angina	**Yes** ☐	**No** ☐	if yes, were they under 60 years of age at onset	**Yes** ☐	**No** ☐			
Heart Attack	**Yes** ☐	**No** ☐	if yes, were they under 60 years of age at onset	**Yes** ☐	**No** ☐			
Stroke	**Yes** ☐	**No** ☐	if yes, were they under 60 years of age at onset	**Yes** ☐	**No** ☐			
High Cholesterol	**Yes** ☐	**No** ☐	Asthma	**Yes** ☐	**No** ☐			
High Blood Pressure	**Yes** ☐	**No** ☐	Diabetes	**Yes** ☐	**No** ☐			
Breast Cancer	**Yes** ☐	**No** ☐						

Which ethnic group do you belong to?			
White	☐	Mixed	☐
Black or Black British	☐	Chinese	☐
Asian or Asian British	☐	Other: Please specify	_____

Do you need an interpreter to be present for any GP appointments? If yes, which language is required?

Are you a carer?	**Yes** ☐	**No** ☐	if yes, who for	_____		
Do you have a carer?	**Yes** ☐	**No** ☐	if yes, please leave contact details	_____		

Have you ever served in the Armed Forces? **Yes** **No**

We are participating in Summary Care Record; we will create one for you unless you wish to opt out. If you do wish to opt out, please inform reception (9Ndo).

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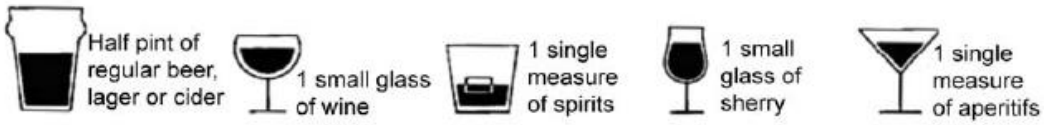
This is one unit of alcohol…



…and each of these is more than one unit

AUDIT – C

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.

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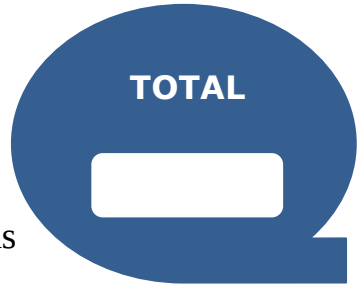
Score from AUDIT- C (other side)

Remaining AUDIT questions

Questions	Scoring system					Your score
	0	1	2	3	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	
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	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 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	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence



TOTAL Score equals
AUDIT C Score (above) +
Score of remaining questions