WEST WALK SURGERY

NEW PATIENT QUESTIONNAIRE

Personal Details

Surname …… First Names……
D.O.B ……
Address ……
……

Telephone Number ……
Mobile Number ……

Email Address – If you do not want to be contacted via email, please leave blank ……

Next of Kin …… Contact Number……
Relationship (i.e. Wife, Son, Mother Etc) - ……

Which ethnic group do you belong to? (please tick one only)

1 - White British
2 - Black or Black British
3 - Asian or Asian British
4 - Mixed British
5 - Chinese
6 - Other ethnic group - please specify ……

What is your first language? ……

Are you a Registered Carer? Yes ☐ No ☐
Or
Are you Cared for? Yes ☐ No ☐

General Health

What is your current weight? …… Kg / St. lbs
What is your current height? …… Cm / Ft. ins

Smoking Status:
Never Smoked ☐
Ex Smoker ☐
Current Smoker ☐

If current smoker, how many per day? ……

Alcohol Consumption

Questions – AUDIT C	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: **TOTAL: .....**

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

If you score more than 5, please complete Part 2 below:

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: .....**

Organ Donation

Are you a currently registered organ donor? Yes ☐ No ☐

Allergies

Are you allergic to, or have you ever had an adverse reaction to, any drugs / non-drugs? Yes ☐ No ☐
If yes, please provide details .....
.....

Vaccinations

When did you have your last Tetanus Vaccination? .....
If eligible, when did you last have a Flu vaccination? .....
If eligible, when did you last have a Pneumococcal Vaccination?.....

If the patient is under 5 years of age, are they up to date with the necessary child immunisations? Yes ☐ No ☐
If not, please give details .....
.....

Treatment

Are you currently on any regular medication, including contraception? If yes please provide a repeat medication slip.
Yes ☐ No ☐
If yes, please provide details .....
.....

Have you been referred to a hospital and currently on any waiting list?
Yes ☐ No ☐
If yes, please provide details .....
.....

Date form completed .....

The information supplied in the questionnaire is strictly confidential

Thank you for registering with West Walk Surgery.