Salisbury Walk in Health Centre

New Patient Medical Questionnaire

Welcome to our Practice

As part of your registration we require you to complete the questions below and offer you a new patient assessment which will provide a good basis for our continuing medical care.

This assessment is carried out by one of our clinicians, and we would be grateful if you could make an appointment for this to be done. Please remember to bring a sample of urine with you when you attend. It will allow information about your relevant past history and family history to be entered on the computer before you need to use the other services in the surgery. We would be happy for you to have a review every three years if we do not see you for any other reason, this being in accordance with Government guidelines. Under 5 year olds will be involved in our Paediatric Surveillance Scheme.

Please complete the form below

………………………………………………………………………………………………......................

I would / would not like a health check (please delete as appropriate)

First Name: ....

Surname: ....

D.O.B: ………………….........

Daytime tel. no: ………………………..

Mobile tel. No: ………………………..

Do you give permission for us to contact you via SMS messaging? Yes / No

Sex: Male / Female

Ethnic origin (please tick):

☐**White, British** ☐**Indian**
☐**White, other** ☐**Chinese**
☐**Black African** ☐**Black Caribbean**
☐**Pakistani** ☐**Bangladeshi**
☐**Vietnamese** ☐**Confidential**

☐**Other**…………………………………….....

First speaking language …………………......

Occupation: ……………………........

Height: ……………..……………**cm/ft**

Weight: ……………….......... **kg/stone**

Do you smoke? Yes / No

If so how many do you smoke? ………

Have you ever smoked? Yes / No
If so when did you stop? ……………….

Are you a carer? Yes / No

If so, would you like to be referred to the Carers Support scheme? Yes / No

Contact details for your Next of Kin

Name: ……………………………........

Tel. No: ……………………………........

Do you suffer or have you suffered from any of the following? (Please circle)

* Coronary heart disease
* Diabetes Mellitus
* Asthma
* Renal failure
* Hypertension
* Epilepsy
* Cancer
*Psoriasis
* Chronic Obstructive Pulmonary disease
* Hypothyroidism
* A mental health problem e.g. depression
* Parkinsons disease

Have you ever had any of the following? (Please circle)

* Heart attack * Stroke * Epileptic fit

How much alcohol do you drink?

Questions	Scoring					Your score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year	
Has a friend / relative / doctor / healthcare worker been concerned about your drinking or advised you to cut down?	No		Yes but not in the last year		Yes during the last year	

Patient’s signature: ……………………………………………………………………………………

Date: …………………………………………………………………………………….

Thank you for taking the time to complete these questions.