

Dr A S Thornton
Dr R M C Leach
Dr E M K Tully
Dr A K Adams
Dr N J Ware
Dr E L Simons
Dr J C Dalton



North Street
Calne
Wiltshire
SN11 0HH

Telephone: (01249) 812141

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete the questionnaire below and hand it in to reception

DATE.....

MR / MRS / MISS / MS / MASTER / OTHER-PLEASE SPECIFY.....

SURNAME.....

PREVIOUS SURNAME.....

FORENAME.....

DATE OF BIRTH.....

MALE / FEMALE

ADDRESS.....

.....

.....

POSTCODE.....

NEXT OF KIN.....

TELEPHONE NO: HOME.....

TELEPHONE NO: WORK.....

TELEPHONE NO: MOBILE.....

E-MAIL ADDRESS.....

MARITAL STATUS: SINGLE / MARRIED / DIVORCED / WIDOW(ER)

OCCUPATION

(What type of work do you do?)

Please continue over the page:-

FAMILY HISTORY: DOES ANY MAJOR ILLNESSES RUN IN YOUR FAMILY, BEFORE THE AGE OF 60 YRS. PLEASE STATE WHICH FAMILY MEMBERS.

HEART ATTACK/ANGINA YES/NO
BLOOD PRESSURE YES/NO
CANCER YES/NO
GLAUCOMA YES/NO

STROKES YES/NO
ASTHMA YES/NO
ECZEMA YES/NO
DIABETES YES/NO

ALLERGIES: PLEASE LIST ANY KNOWN ALLERGIES, ESPECIALLY TO MEDICINES

.....

SMOKING: PLEASE CIRCLE ONE OPTION

NEVER SMOKED / CURRENT SMOKER / USED TO SMOKE BUT NOT NOW

EXERCISE: DO YOU TAKE ANY REGULAR EXERCISE? IF SO, WHAT AND HOW MUCH?

.....

DIET: ARE YOU ON ANY SPECIAL DIET? YES/NO IF YES, PLEASE GIVE DETAILS.

.....

WOMEN ONLY: HAVE YOU HAD A CERVICAL SMEAR? YES/NO

DATE OF LAST SMEAR.....

DO YOU USE CONTRACEPTION? YES/NO TYPE?

CURRENT MEDICATION: PLEASE LIST AND INCLUDE DOSEAGE IF KNOWN, OR ATTACH YOUR CURRENT REPEAT PRESCRIPTION LIST.

.....

.....

.....

PAST MEDICAL HISTORY: PLEASE LIST ANY SERIOUS ILLNESSES, OPERATIONS OR ACCIDENTS, WITH DATES.






.....

.....

.....

.....

Please continue over the page:-

Standard alcoholic drinks (units of alcohol)						
						
Pint of Regular Beer/Lager/Cider	Alcopop or Can of Lager	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine		
Questions	Score					Your score
	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks (units) do you have on a typical day when you are drinking? (e.g. if you drink 2 glasses of wine you score 1)	1 – 2 units	3 - 4 units	5 - 6 units	7 - 8 units	10+ units	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
If your total score is 5 or more, please complete the further Alcohol Questionnaire below.						

Further Alcohol Questionnaire

Questions	Score					Your score
	0	1	2	3	4	
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 relative/friend/doctor/health 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	
Total						

Please continue over the page:-

**PLEASE COMPLETE YOUR ETHNIC ORIGIN
BY TICKING OR CIRCLING THE APPROPRIATE OPTION:-**

**WHITE BRITISH
WHITE IRISH
OTHER WHITE BACKGROUND**

**MIXED WHITE & BLACK CARIBBEAN
MIXED WHITE & BLACK AFRICAN
WHITE & ASIAN
OTHER MIXED BACKGROUND**

**INDIAN
PAKISTANI
BANGLADESHI
OTHER ASIAN BACKGROUND**

**CARIBBEAN
AFRICAN
OTHER BLACK BACKGROUND**

CHINESE

OTHER

DECLINED/NOT GIVEN

PLEASE STATE YOUR FIRST LANGUAGE.....

Thank you for completing this form, we invite all new patients to make an appointment with a doctor or nurse for a new patient check, if you would like to do this please ask at reception. We request that you bring a urine sample along to your first appointment.