

# BRUNTON PARK HEALTH CENTRE

## NEW PATIENT QUESTIONNAIRE

<b>Title:</b> _____	<b>Name:</b> _____	<b>DOB:</b> _____
<b>Address:</b> _____ _____	<b>Tel:</b> _____	<b>Mob:</b> _____
<b>Occupation:</b> _____	<b>Email:</b> _____	

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

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

Do you have any ongoing medical conditions or have you had any serious illnesses or operations? Please specify			<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
_____	_____	_____		

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

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

Do you regularly perform any physically strenuous activities, e.g. sports, gardening cycling etc	<b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
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P.T.O.

Are you allergic to anything?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	If yes what? _____
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For women when was your last cervical smear? _____
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Do you take an oral contraceptive pill? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>			
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	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	if yes, were they under 60 years of age at onset	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
Heart Attack	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	if yes, were they under 60 years of age at onset	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
Stroke	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	if yes, were they under 60 years of age at onset	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
High Cholesterol	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	Asthma	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
High Blood Pressure	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>	Diabetes	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>
Breast Cancer	<b>Yes</b>	<input type="checkbox"/>	<b>No</b>	<input type="checkbox"/>					

Which ethnic group do you belong to?	
White <input type="checkbox"/>	Mixed <input type="checkbox"/>
Black or Black British <input type="checkbox"/>	Chinese <input type="checkbox"/>
Asian or Asian British <input type="checkbox"/>	Other: Please specify _____

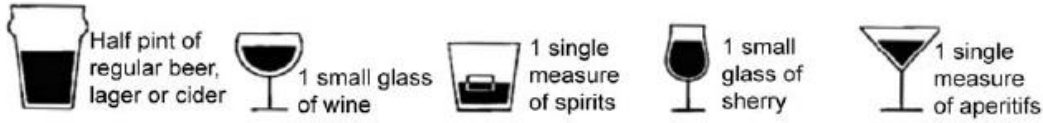
Are you a carer? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	if yes, who for _____
Do you have a carer? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	if yes, please leave contact details _____

Have you ever served in the Armed Forces?	<b>Yes</b>	<b>No</b>
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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 ask for form from reception.

# BRUNTON PARK HEALTH CENTRE NEW PATIENT QUESTIONNAIRE

## 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.



# BRUNTON PARK HEALTH CENTRE NEW PATIENT QUESTIONNAIRE

**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