THE MANOR PRACTICE
CONFIDENTIAL
NEW PATIENT REGISTRATION / HEALTH QUESTIONNAIRE

To the Patient:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment.

Surname: ………………………………….. Forename(s): …………………………………

Date of Birth: …………… Marital status: ….……………………………

Address: ……………………………………………………………………………………………..

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

Postcode: ……………………….School attended (if applicable)……………………………………

Home Tel: ………………………………… Mobile: ………………………………….…

Email address: ……………………………………………………………………………………………

Occupation: …………………………………………………………………………………………….

Weight (approx): ……………………………………….. Height: ……………………………………………

Next of Kin: Name ……………………………………Address …………………………………………………

Contact No:………………………………………………………………………………………………

Do you have special communication needs e.g Speech , Hearing , Visual that may require the services of one or more of the following?:

An Interpreter ………………………

British Sign Language Support………………..

Deaf Blind Manual Interpreter………………..

An Advocate…………………………………..

Date of completion of this form: ……………………………………………………………………….

EQUAL OPPORTUNITY POLICY

In line with your equal opportunity policy and the NHS Department's requirements please complete the following information:

MY SPOKEN LANGUAGE IS………………………………

I would describe my ethnic origin as:

White British	White Irish	Other White Background
Mixed White and Black Caribbean	Mixed White and Black African	White and Asia
Other Mixed Background	Indian	Pakistani
Bangladeshi	Chinese	Other Asian Background
Caribbean	African	Other Black Background
Chinese	Other	Declined / Not Given

SMOKING

Do you smoke? Yes / No

If Yes, how many:

Cigarettes per day …….. Cigars per day ..….. Ounces of tobacco per day ……..

How old were you when you started smoking? …………………..

EX-SMOKERS

How old were you when you stopped smoking? …………………

How much did you smoke per day? …………………………………..

HAVE YOU NEVER SMOKED ? Yes / No

PERSONAL HEALTH

Do you try to keep fit by:

Swimming	YES / NO	Running	YES / NO
Going to the Gym	YES / NO	Cycling	YES / NO
Walking	YES / NO		

Do you exercise daily? Weekly? Occasionally?

FAMILY HISTORY

Has any of your immediate family (parents, brothers, sisters, grandparents, etc) suffered from any of the following? Please indicate which relative and age (if known)

Heart Attack	Yes/No	Which relative? ……………………	Age ………………
Angina	Yes/No	Which relative? …………………….	Age ………………
Stroke	Yes/No	Which relative? …………………….	Age …………..……
Asthma	Yes/No	Which relative? …………………….	Age ……………….
Diabetes	Yes/No	Which relative? …………………….	Age……………… …
Cancer	Yes/No	Which relative and type of cancer? ………………………………………	Age ………………

REPEAT MEDICATION

Please give details of any regular medication you are currently taking:

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

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

DO YOU HAVE ANY ALLERGIES?

FEMALE PATIENTS ONLY

Have you had any pregnancies?

Yes / No

How Many ?

Do you have any contraception needs?

Have you ever had a mammogram?

Have you ever had a cervical smear test?

CARERS

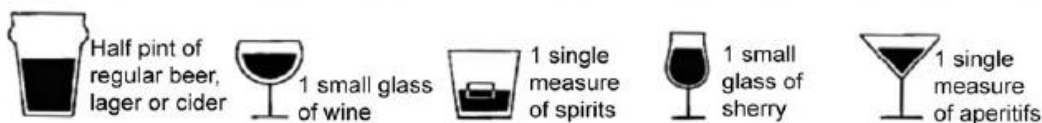
Do you need / have anyone who looks after you or your daily needs as Carer? Yes / No

If “Yes” please supply name and contact details:………………………………………………………………
……….

Do you care for anyone else? Yes / No

Are they a patient of this practice? Yes / No
If ‘’Yes’’ please supply their contact details.

This is one unit of alcohol…



…and each of these is more than one unit

FAST	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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:
If score is 0, 1 or 2 on the first question continue with the next three questions

If score is 3 or 4 on the first question – stop here.
An overall total score of 3 or more is FAST positive.

What to do next?
If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

Score from FAST (other side)

Remaining AUDIT questions

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 - 8	10+	
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 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	
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	

TOTAL AUDIT Score (all 10 questions completed):
0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence