Belford Medical Practice
New Patient Registration/Health Questionnaire

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. Patients will be asked to attend the practice for an initial consultation and some basic checks. Date of completion of this form: ……

Surname: …… Forename(s): …….…… Date of Birth: ……

Marital status: …… Previous Surname: ……..

Address: ……

…… Postcode: ……..……..

Home tel: ……..…….…… Mobile: ……..……..…..

Email address: ……

Occupation: ……

Weight : …….…….. Height: ……..……..

Blood Pressure:……..

What is your ethnic group? What is your first language?

Smoking

Do you smoke? *Yes* / *No*

If *Yes*, how many…: Cigarettes 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? ……..

Alcohol

Alcohol - 1 unit = ½ pint of beer, 1 small glass of wine or 1 single spirit.

1. How often do you have a drink containing alcohol? 0 – Never 1 - Monthly or less
2 - 2 to 4 times a MONTH 3 - 2 to 3 times a WEEK 4 - 4 or more times a week

If you replied never to Question 1, please skip Questions 2 -8 and answer only Questions 9 and 10

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
0 - 1 or 2 drinks 1 - 3 or 4 drinks 2 - 5 or 6 drinks 3 - 7 or 8 or 9 drinks 4 - 10 or more drinks

3. How often do you have six or more drinks on one occasion?
0 - Never 1 - Less than monthly 2 – Monthly 3 – Weekly 4 - Daily or almost daily

If you scored 0 points to Questions 2 and 3, please skip Questions 4 -8 and answer only Questions 9 and 10. Otherwise continue with all Questions.

4. How often during the last year have you found that you were not able to stop drinking once you had started?
0 – Never 1 - Less than monthly 2 – Monthly 3 – Weekly 4 - Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
0 - Never 1 - Less than monthly 2 - Monthly 3 – Weekly 4 - Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
0 - Never 1 - Less than monthly 2 – Monthly 3 - Weekly 4 - Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
0 - Never 1 - Less than monthly 2 - Monthly 3 – Weekly 4 - Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
0 - No, never 2 - Yes, but not in the last year 4 - Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
0 - No, never 2 - Yes, but not in the last year 4 - Yes, during the last year

Scores of 8 or more are considered an indicator of hazardous and harmful alcohol use. If your score is higher than 8 we will contact you to discuss this with you further

Exercise

Do you take regular exercise? *Yes* / *No*

If yes, what sort of exercise? ……..

How many minutes do you typically spend exercising per session? ……

How many times do you exercise per week? ……..

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease (e.g. heart attacks, angina) *Yes* / *No* which family member? ……..

Stroke *Yes* / *No* which family member? ……..

Cancer *Yes* / *No* which family member? ……..

Site of cancer? ……

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……

Dosage: ……..

Name of drug: ……

Dosage: ……..

Name of drug: ……

Dosage: ……..

Allergies

Are you allergic to any substances, including medication or foods? *Yes* / *No*

If *Yes*, please give details:

Female Patients

Date of most recent cervical smear: ……..

Result of most recent smear: ……

Carers

Does someone look after you? Or do you need / have anyone who looks after you or your daily needs as a Carer? *Yes* / *No*

If *Yes*, would you like them to deal with your health affairs here? *Yes* / *No*
The receptionist can help with these arrangements

Do you look after someone else? *Yes* / *No*
If *Yes*, please ask the receptionist about Carers support

Emergency Contact Details
Name relationship

Contact Telephone No

Communication with Patient
Please let us know if you have any communication/information needs relating to a disability or sensory loss and if so what they are.

Consent to Share
The practice is signed up to Summary Care Record Sharing, this will allow hospitals and other health care professionals to access your records and obtain a history of medication you take and also any allergies that you might have.

Consent for SCR Yes No

Consent for SMS/Email
Please tick the box on the right if you agree to be contacted from time to time via email and/or SMS text message with clinics and/or appointment reminders ☐

Thank you for completing this questionnaire.