BUCKSHAW VILLAGE SURGERY

New Registration Screening Questionnaire

Please complete as much of this form as possible to enable the GP/Nurse to provide you the best treatment in the future.

Details

Name _____ Date of Birth_____

Sex Male / Female Occupation _____

Address_____

Home Tel. Number_____ Mobile _____

Email _____Faith _____

Height _____ Weight _____

Please give details of any disability you would like us to be aware of

_____

Family History

Has your mother, father, brother or sister had/has:

			Which family member?	What age were they diagnosed?
Heart Attack	YES	NO	_____	_____
Angina	YES	NO	_____	_____
Stroke	YES	NO	_____	_____
Kidney Disease	YES	NO	_____	_____
Diabetes	YES	NO	_____	_____

Please tick (✓) the box that best describes your ethnic origin

White British	☐	Indian	☐	Chinese	☐
White Irish	☐	Pakistani	☐	Caribbean	☐
		Bangladeshi	☐	African	☐

Other – Please specify _____

First language _____

Female Patients

Date of most recent cervical smear: ……..
Result of most recent smear: …….
Please give details of any complications in pregnancy:
……

Smoking Status.

Never Smoked ☐

Current Smoker ☐

Ex Smoker – less than 5 years ☐

Ex Smoker – more than 5 years ☐

Alcohol Intake

No of Alcohol Units per week ☐

How often do you eat fruit or vegetables?

Everyday ☐ Not every day ☐

Do you usually have at least 30 minutes physical activity daily, either at work and/or during leisure time? (including normal activity)

Everyday ☐ Not every day ☐

Immunisations

Dates of Triple/polio/HIB:
……..

Dates of MMR:
……..……..

Date of last Tetanus:
…….

Past medical history

Please give details of any hospital treatment as an in-patient:

……..……

……

Please give details of any chronic medical conditions you have and any treatments received:
……

……

……

……

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

……

Alcohol – 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 had 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				**TOTAL SCORE**		

IF YOU SCORED 5 OR ABOVE ON THE ABOVE QUESTIONS PLEASE ANSWER THE QUESTIONS BELOW – THANK YOU

Alcohol – AUDIT -C Remaining 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 inured 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**	

Sexual orientation

Please indicate your sexual orientation below. **This is not compulsory**, but may help with your healthcare. Please remember that all information, no matter how sensitive, is dealt with in the strictest confidence.

☐ Heterosexual

☐ Homosexual

☐ Bisexual

☐ Lesbian

☐ Unknown

Carers

Do you need / have anyone who looks after you or your daily needs as 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)

Carer's Details:

Name: _____

Address: _____

_____

Tel No: _____ Mobile: _____

Do you care for anyone else? Yes / No
If "Yes", ask the receptionist about Carers support

Thank you for completing this questionnaire. The Receptionist will make you an appointment for a health check with the Nurse.