Highgate Surgery (Hill Brow Partnership)
The Grimethorpe Centre, Acorn Way, Grimethorpe, Barnsley, S72 7NZ
Tel: (01226) 707414 Fax: (01226) 707486

NEW PATIENT QUESTIONNAIRE

New patients notes sometimes take a number of weeks to arrive from the previous doctor. Please can you complete the following questions to give your new doctor valuable background information about your general health.

You will also be given an appointment with our Health Care Assistant who will give you a full health check. It is very important that you keep this appointment as it helps us to help you. All information given will be treated in the strictest confidence.

GENERAL DETAILS:- Today's Date:- ……………………………………………….

Name ………………………………………..………………………………. Date of Birth ..…………..
Address ……………………………………………………………………………………………...
….……………………………………………………………………………………………………
Telephone Number - Home …………………………… Work ………………………………………
Single/Married/Divorced/Widowed/Living with Partner …………………………………………………...
Number of Children ………………… What are their ages ..………………………………………………
Name and telephone number of next of kin…………………………………………………………………
Occupation ……………………………………………………………………………………………..

Are you the sole 'carer' of any disabled or elderly relative or friend? YES/NO
If YES indicate as follows
Parent(s) □ Parent(s) in law □ Husband □ Wife □ Partner □ Daughter □
Son □ Other Family Member □ Friend □ Neighbour □

FOR WOMEN:- Are your smears up to date? YES/NO
If YES - Please give year of last smear ……………….

Height …………………………………………… Weight …………………………………………………...

Do you smoke? YES/NO/STOPPED SMOKING
If YES - Cigarettes/Cigars/Pipe/Roll own Cigarettes How many per day? ………
If STOPPED SMOKING - When did you stop? …………………… How many did you smoke? ....
Do you consider yourself at risk from passive smoking? YES/NO

Alcohol consumption – please complete the questionnaire below:

QUESTIONS	0	1	2	3	4	YOUR SCORE
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 do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
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+ please complete the form at the end of the New Patient Questionnaire

Are you allergic to anything? (Give details) …………………………………………………………...
………..

Do you take exercise? YES/NO
Type of exercise: Mild □ Moderate □ Exertive □
How many 30 minute blocks per week? ………………………………………..

Are you on a weight reducing diet? YES/NO
Are you on a Gluten Free diet? YES/NO
Are you on a Vegetarian diet? YES/NO
Are you on a Vegan diet? YES/NO
Are you on a low fat diet? YES/NO
Are you on a low salt diet? YES/NO
How many portions of fruit and vegetables do you eat per day? ……………………

MEDICAL HISTORY - Please give brief details of any illness which you have suffered, hospital admission, investigations or tests, and the date or year.
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……
…………………………………………………………………………………………

MEDICATION - Are you taking any medication at present? YES/NO
If YES - Please give details below.

Name	Dose	What is it for?

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

FAMILY HISTORY - Have any of your close relatives (Grandparents/Parents/Sisters/Brothers/ Aunts/Uncles) suffered from any serious illness (for example, Heart Disease, High Cholesterol, Angina, Asthma, Broncitis/COAD, Cancer, Diabetes, Heart Attack, Raised Blood Pressure, Stroke)?

Relation	Illness

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

Are you in good health at the present time? YES/NO

Have you any illness or other problem you wish to discuss? YES/NO

Do you use any form of contraception? ……………………………………………………………………….

ETHNIC CATEGORY (TICK AS APPROPRIATE)

White British		Pakistani	
White Irish		Bangladeshi	
Any Other White Background		Any Other Asian Background	
White and Black Caribbean		Black Caribbean	
White and Black African		Black African	
White and Asian		Any Other Black Background	
Any Other Mixed Background		Chinese	
Indian		Any Other Ethnic Group	

MAIN LANGUAGE SPOKEN (PLEASE INDICATE BELOW)

English YES/NO

If NO please specify your main language…………………………………………………………………

ALCOHOL USERS DISORDERS IDENTIFICATION TEST

Name: …………………………….
Date of birth …………………………….

QUESTIONS	0	1	2	3	4	YOUR SCORE
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 standards alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 last year		Yes, but not in 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 last year		Yes, but not in last year	

Total ………

Scoring: 0-7 sensible drinking, 8-15 hazardous drinking, 16-19 harmful drinking and 20+ possible dependence