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PRIORY AVENUE SURGERY
2 PRIORY AVENUE
CAVERSHAM
READING
RG4 7SE

NEW PATIENT QUESTIONNAIRE – CONFIDENTIAL

Please complete the following form IN BLOCK CAPITALS and return it to the surgery so that we can go ahead with your registration. The information provided will be entered into your computer record, and will help us to give you the best possible care, especially if you also respond to the invitation for a health check with the Practice Nurse.

Full Name: Mr/Mrs/Ms/Miss/Other (please specify)

Previous Surname/s: **Date of Birth (dd/mm/yyyy):** **Sex:** Male/Female

Marital Status: Single/Married/Widowed/Divorced/Cohabiting **Occupation:**

Address:

Tel. No.:(home)(work)(mobile)

Ethnic Origin (please circle): *Please note this information is used to establish disease trends*

White British	Indian	Mixed white/black Caribbean
White Irish	Pakistani	Mixed white black African
Other white	Bangladeshi	Mixed white/Asian
Black Caribbean	Chinese	Other mixed
Black African	Other Asian	Other ethnic group
Other black		(Please specify)

Religion: **First spoken Language:**

Place of birth: Town..... **Country (if not UK)**

Next of Kin (name & relationship to yourself): **Address:**

..... **Tel. No.:**

Are you a carer for anyone? Yes/No If yes, whom for?

Do you have a carer? Yes/No If yes, please give name and address:

.....

Alcohol intake:

Please see separate questionnaire.

Do you currently smoke? Yes/No **If yes, how many a day?**

Have you ever smoked? Yes/No **If you have stopped smoking, how long ago?**

Please Turn Over

Height: **Weight:** **When was your last tetanus vaccination?**

Please give details of any regular exercise you undertake:

Please list below any regular medication that you take, whether you get it from your doctor or buy it over the counter?

Important - Please make an appointment to see your doctor before any medication runs out.

Do you have any known allergies? Yes/No If yes, then please list below:

Past medical history - please list any conditions (not minor) you have suffered from in the past, with dates if possible:

Do you have any current medical problems? Yes/No If yes, then please explain below:

Are you on a waiting list for a hospital appointment? Yes/No

If yes, please describe:

Have your parents, brothers, sisters or children ever suffered from (please circle)?

Heart disease	Diabetes	Stroke	Cancer
Asthma	High blood pressure	Glaucoma	Other

If yes, then please give further details below, including family member affected:

Is there anything else you wish to tell us about?

If you would like an appointment with one of our doctors, then please tick

If you would like to see the nurse for a general health check, then please tick

Signed **Date**

Ladies

When was your last cervical smear? **Was it normal/abnormal?**

Was the smear carried out under the NHS? Yes/No If no, where?

If you have had a normal smear within the last 3 years outside of the NHS, and do not wish to be offered another smear until the next smear is due, the receptionist will give you a form to sign that gives us permission not to invite you. Otherwise, we are obliged to send you an invitation on a regular basis, until you have a smear.

Have you ever had a mammogram? Yes/No If yes, when was your last one?

Have you had a hysterectomy? Yes/No If yes, (a) when was it?
(b) what was the reason?

Children

Please supply dates of any immunisations your child has received:

- 2 months old:** Diphtheria, Tetanus, Pertussis (whooping cough), Polio, Hib
Pneumococcal
- 3 months old:** Diphtheria, Tetanus, Pertussis, Polio, Hib
Meningitis C
- 4 months old:** Diphtheria, Tetanus, Pertussis, Polio, Hib
Meningitis C
- Pneumococcal
- Between 12 and 13 months:** Hib/MenC, Pneumococcal
Measles, Mumps and Rubella
- 3 years 4 months old:** Diphtheria, Tetanus, Pertussis and Polio
Measles, Mumps and Rubella
- Girls aged 12 to 13 years:** HPV
- 13 to 18 years old :** Tetanus, Diphtheria and Polio

Non-routine immunisation schedule

- At Birth** Tuberculosis
- Hepatitis B

Any others not listed above (e.g. travel vaccinations)

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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 - 8	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.

