Please state any known non-drug allergies (ie animal, elastoplast):

Height …………….   Weight ……………..

Women Only

What if any, contraception form do you use?

Date of last cervical smear …………………

Date of last mammogram …………………

Family History – Is there any history of the following in your immediate family ie Mother, Father, Brother or Sister. Please specify family member affected.

Heart attack		Heart disease		Angina	
Glaucoma		Cystic Fibrosis		Epilepsy	
Diabetes		Depression		High blood pressure	
Bowel cancer		Breast cancer		Stroke	
Other please specify					

NEW PATIENT SIGNATURE……………………………… Date ………………………………………...

FOR HEALTH ADVICE AND INFORMATION
PLEASE LOOK AT OUR WEBSITE
www.branstonsurgery.co.uk

The Branston & Heighington Family Practice
Station Road
Branston
Lincoln LN4 1LH
VAT Reg No. 879 1249 81

www.branstonsurgery.co.uk

NEW PATIENT HEALTH QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS THAT ARE RELEVANT TO YOU

Welcome to our practice. It may be some time before your records reach us. The absence of these records may impair the service, which we wish to give you. It is in the interest of both yourself and your doctor that you fill in this questionnaire to the best of your knowledge.

Surname	Forename/s	DoB
Address	Tel. No Home Work	Occupation - Religion - First Language -

Ethnic Origin (ie, White, Afrocaribbean, Asian ……………………………………………………………………………

Have you ever been in the Forces? (YES/NO) If yes, dates From: To:

Have you ever lived abroad? (YES/NO) If yes, dates From: To:

Are you a Carer? (YES/NO) If yes, details:

Does someone care for you? (YES/NO) If yes, details:

Next of Kin	Address	Tel. No

Exercise - How often do you exercise? (please tick)

A	Exercise is physically impossible	
B	Avoids even trivial exercise	
C	Enjoys light exercise	
D	Moderate exercise	
E	Enjoys heavy exercise	

Please tick if you suffer from or have ever had any of the following conditions. Please give the approximate dates.

Asthma		Heart Trouble		High Blood Pressure	
Hayfever		Angina		Peptic Ulcer	
T.B.		Thyroid Disease		Bowel Trouble	
Pneumonia/Bronchitis		Epilepsy		Bladder/Kidney disease	
Diabetes		Arthritis/Joint Problems		Stroke	
Depression/Nervous Trouble		Gynae. Problems		Cataracts	
Glaucoma		Migraine			

Do you have any other Health problem or Health Risk that the Doctor / Nurse should be aware of?

Have you ever had an operation? Please list below with date:

Do you take any medication? Please enclose a copy of last repeat prescription slip.

Please state any known drug allergies:

Name of Drug/s ……………………………………… Reaction ………………………………………

Smoking Status - Please tell us if you do/do not smoke? (please tick)

A	I have never smoked	
B	I used to smoke but I do not smoke now	
C	I do smoke but I do not want help in giving up at the moment	
D	I do smoke and would like help in giving up	

If you are a smoker;

How many cigarettes do you smoke each week: ....

How many cigars do you smoke each week? ....

If you are a pipe smoker, how many times a week? ....

When did you start smoking? ....

If you are an ex-smoker, when did you start/stop? ....

How many did you smoke?...

Questions	Scoring System 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 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Please circle your answer.

Scoring: A total of 5+ indicates hazardous or harmful drinking

This brief intervention package is based on the Drink-less programme originally developed at the University of Sydney as part of a W.H.O. collaborative study. ©Institute of Health & Society, Newcastle University. Produced by Design Services, Gateshead Council.

UNITS

2	1.5	2	1	9
Pint of Regular Beer/Lager/Cider	Alcopop or Can of Lager	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine

How many drinks do you consume per week? ………………………………

Note: 1 Drink = $\frac{1}{2}$ pint of beer or 1 glass of wine or 1 single spirits

When you return this form please enclose a copy of your last repeat medication slip for input onto our records.

Thank you