St Quintin Health Centre

First name: _____ Surname: _____

Date of Birth: _____/_____/_____

HEALTH QUESTIONNAIRE

Height:		Weight:	
Blood Pressure checked in the last 5 years		Yes: ☐	No: ☐

SMOKING (Please tick and answer as appropriate)

Do You Smoke?	Yes: ☐	No: ☐
Cigarettes - how many per day:		
Cigars – how many per day:		
Tobacco – ounces per day:		
If you smoked, how old were you when you stopped?		
If you used to smoke, how many did you smoke per day?		

FAMILY HISTORY (Please tick and answer as appropriate)

Have any of your family (*father, mother, brother, sister, grandparents*), had any of the following before the age of 65?

Heart Disease (Heart attack, angina)	Yes: ☐ No: ☐	Which family member?
Stroke	Yes: ☐ No: ☐	Which family member?
Cancer	Yes: ☐ No: ☐	Which family member?
Site of Cancer:		
Diabetes	Yes: ☐ No: ☐	Which family member?
Asthma	Yes: ☐ No: ☐	Which family member?

ALLERGIES

If you have an allergies please write them down below, e.g. hay fever, pollen, penicillin:

Allergy 1.	
Allergy 2.	
Allergy 3.	
Others \ Phobias:	

Your occupation \ job:	
Your religion:	

Next of Kin\Family – Name and Contact Number	

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Specific Needs: **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:**				
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):				
Are you an 'Assistance Dog' User?				
Please state any Physical disabilities you have:				
Please state any Mental disabilities you have:				
Please state any requirements you have to be able to access the Practice premises				
Please state any Religious or Cultural needs:				
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**			
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**			
	Signed: **Date:**			
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***		
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**		

Women only:				
When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

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The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential. So please be honest.
Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
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	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	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?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
7. 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	
8. How often during the last year have you been unable to remember what happened the night before because of the drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

If you drink – how many units per week: (1 unit is ½ pint of beer, 1 small glass of wine, I single measure of spirit)	

Add up the scores from each line (0 – 4) to come to a final total>

Scores:	8-15	Hazardous Drinking	Discuss with GP or Practice Nurse
	16-19	Harmful Drinking	May benefit from support service
	20+	Alcohol Dependence	Input from specialised services may be warranted

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ETHNIC ORIGIN (Please either write your ethnic origin below or select one of the following)

Your ethnic origin:	

White British	☐		
White Irish	☐		
White European	☐	Please state:	
White Other	☐	Please state:	

Black British	☐		
White and Black Caribbean	☐		
White and Black African	☐		
White and Asian	☐		
Mixed other	☐	Please state:	

Indian\British Indian	☐		
Pakistani\British Pakistani	☐		
Bangladeshi\British Bangladeshi	☐		
Asian Other	☐	Please state:	

Chinese	☐		
Vietnamese	☐		
Any other ethnic group	☐	Please state:	
No category assigned	☐		

Your first language:	

Patient Signature:		**Signature on behalf of Patient:**	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

The Consultation will also establish relevant past medical and family history, including:

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

Thank you for completing this form

For more information about the services we offer, please refer to our Practice leaflet