New Patient Questionnaire

(age 16 years and over)

Name: .... Date of Birth: ....

Mobile✆ : .... What is your first language? ....

Home☎: .... Email💻: ....

Work☎: .... Military Veteran: YES / NO

Please ✓ as appropriate:-

- ☐ I am over 16 years and would like a **SystmOne Online Account** *(to book appointments, request repeat medication, view test results etc)*. Please note that we must have an email address for this service to commence so we can email your login details to you.
- ☐ I am NOT happy to receive text reminders from St Austell Healthcare

New Patient Check

As a new patient to St Austell Healthcare, we offer a New Patient Check with a Healthcare Assistant (HCA) who will check your weight, height, blood pressure, medical history and carry out any blood tests as necessary.

Please ✓ as appropriate:-

- ☐ I am happy with my current state of health and do not wish to take up this offer. *or*
- ☐ I will make an appointment for a New Patient Check with a HCA.

Smoking Status *please tick✓*

Smoker ☐
Never smoked tobacco ☐
Ex-Smoker ☐

Height & Weight

What is your height? ....
What is your weight? ....

If you are a smoker, would you like advice on giving up smoking? Yes ☐ No ☐

Next of Kin

Please give name, address and telephone number of your next of kin:

Name: .... Tel: .... Relationship to you: ....

Address: ....

Carers

Do you have a relative, friend or neighbour who looks after you without payment? Yes ☐ No ☐
If yes, please give name and contact details: ....

Do you look after a sick, disabled or frail relative, friend or neighbour without payment? Yes ☐ No ☐
If yes, please give name and details: ....

Health Conditions – **Do you or have you had any of the following conditions? (Please ✓ boxes that apply)**

Asthma	☐	Heart Disease	☐	Cancer	☐
COPD	☐	Stroke	☐	Learning Disability	☐
High Blood Pressure Severe	☐	Epilepsy	☐	Currently receiving B12 injections	☐
Diabetes	☐	Dementia	☐		

Allergies

Do you have any allergies? ....

Medication

Are you on any repeat medications?..
(Please attach a re-order form or packet if available)

Pharmacy

We are an electronic prescribing practice; this means that we are able to send your prescriptions direct to your chosen pharmacy without printing. Your medicines will be sent to the pharmacy within 3 working days of submitting your request. If you would like your prescriptions to go in this manner please nominate your preferred pharmacy. If you are new to the area please ask a member of the reception team who will be able to advise you of your nearest pharmacy.

Pharmacy name: .... Location:..

ST AUSTELL HEALTHCARE

Alcohol Intake Questionnaire

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 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	
					TOTAL:	

A score of **less than 5** indicates *lower risk drinking*

Scores of 5 or more requires the following 7 questions to be completed:

AUDIT QUESTIONS (after completing 3 AUDIT-C questions above)	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 injured as a result of your drinking?	No		Yes, but not in last year		Yes, during 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 last year		Yes, during last year	
					TOTAL:	

Ethnic Origin &Nationality

This questionnaire follows the recommendations of the Equality and Human Rights Commission Act.

A **White**
- ☐ British or Mixed British
- ☐ Irish
- ☐ Other white background, please specify:

……………………………………………………………………

B **Mixed Background**
- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Other mixed background, please specify:

……………………………………………………………………

C **Asian or Asian British**
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Other Asian Background, please specify:

……………………………………………………………………

D **Black or Black British**
- ☐ Caribbean
- ☐ African
- ☐ Other Black Background, please specify:

……………………………………………………………………

E **Other -** Please specify

……………………………………………………………………