KINGSWOOD SURGERY
14 WETHERBY ROAD
HARROGATE
HG2 7SA

New Patient Questionnaire

Welcome to Kingswood Surgery, please complete this form to assist us with your care.

Personal Information

Name (Mr/ Mrs/ Miss/ Ms/Other) ……

Address……..……

……..Postcode……..

Home telephone……..……Work telephone ……

Mobile telephone…… (please remember to inform us if these telephone numbers change)

Email address…….

Date of birth…….……(date)……..…..(month)……(year)

Occupation……...… Marital Status……

Ethnic Group (for example White British/ Asian/ Black African) ……..……

Height…….Weight……

Do you smoke? Yes / No If Yes how many per day?……

Have you ever smoked? Yes / No If Yes when did you stop?……

Would you like the nurse to contact you with regards to stopping smoking? Yes / No
(If Yes please add Read code XaItC to record and send a task to the nurse.)

Alcohol consumption – **please complete the attached sheet, thank you.**

Next of kin details (name, address, phone number and relationship to you)

……

Are you the main carer for an elderly, infirm or disabled person? A carer is defined as a person of any age, adult or child, who provides unpaid support to a partner, child, relative or

friend, who couldn't manage without this help. This could be due to frailty, disability or serious health condition, mental ill-health or substance misuse.……..…….Yes/No

If Yes please state who you care for……

Please describe any allergies you suffer from……

Have any members of your family suffered from any of the following? (if Yes, please state relationship to you e.g father, sister, grandfather etc)

Heart attack before the age of 60	Yes / No	……
Heart attack after the age of 60	Yes / No	……
Angina before the age of 60	Yes / No	……
Angina after the age of 60	Yes / No	……
Stroke	Yes / No	……
Diabetes	Yes / No	……
Asthma	Yes / No	……
Glaucoma	Yes / No	……
High blood pressure	Yes / No	……

If you take any medication on a regular basis please provide the surgery with your latest repeat order form. If not available then please provide us with the full details of all repeat medication below. Please note that it may be necessary to see a GP before these can be issued for the first time as a new patient.

Name of drug	Strength	Dose	Date last issued
…….			
…….			
…….			
…….			

You are welcome to book an appointment for a New Patient Health Check with the Healthcare Assistant if you would like to have one; this will include recording your height, weight, blood pressure and other general advice. Please see the Receptionist to book this.

Prescriptions are sent electronically to your nominated pharmacy. Please tell us below which pharmacy you would like to use.

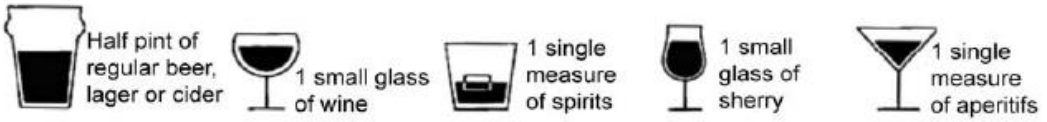
. …….

Thank you.

Signature…….. **Date** ……..

FAST ALCOHOL SCREENING TEST

This is one unit of alcohol…



…and each of these is more than one unit

FAST	Scoring system					Your score
	0	1	2	3	4	
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	
Only answer the following questions if the answer above is Never (0), Less than monthly (1) or Monthly (2). Stop here if the answer is Weekly (3) or Daily (4).						
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 been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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 the last year		Yes, during the last year	

Scoring:
If score is 0, 1 or 2 on the first question
continue with the next three questions

If score is 3 or 4 on the first question – stop here.
An overall total score of 3 or more is FAST positive.

What to do next?

SCORE

If FAST positive, complete remaining AUDIT questions (this may include the three remaining questions above as well as the six questions on the second page) to obtain a full AUDIT score.

Score from FAST (other side)

Remaining AUDIT questions

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 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 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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	

TOTAL AUDIT Score (all 10 questions completed):
0 – 7 Lower risk,
8 – 15 Increasing risk,
16 – 19 Higher risk,
20+ Possible dependence