

**COLLINGWOOD HEALTH GROUP – NEW PATIENT QUESTIONNAIRE**

**Questions in shaded boxes must be answered**

**YOUR DETAILS**

Surname:	<input type="text"/>	Date of Birth:	<input type="text"/>
First Name(s):	<input type="text"/>		
Previous Surname:	<input type="text"/>		
Tel: (Home)	<input type="text"/>		
Tel: (Mob)	<input type="text"/>		
Do you wish to opt out of receiving SMS messages?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you wish to opt out of receiving email notifications?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are you currently employed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, your occupation:	<input type="text"/>		
Are you a carer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, who for: <input type="text"/>
Do you have a nominated Pharmacy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Would you like to keep this? Yes <input type="checkbox"/> No <input type="checkbox"/>
Tel: (Work)	Marital Status: <input type="text"/>		
Email:	<input type="text"/>		

Do you have problems with:	Your sight?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, do you require assistance with this?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Your hearing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If Yes, do you require assistance with this?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**NEXT OF KIN DETAILS**

Title:	<input type="text"/>	Address:	<input type="text"/>
First Name:	<input type="text"/>		(Home)
Surname:	<input type="text"/>	(Mob)	<input type="text"/>
Relationship to you:	<input type="text"/>	Can we discuss your record with them? Yes <input type="checkbox"/> No <input type="checkbox"/>	

**SUMMARY CARE RECORD (SCR) – If you are over 16 you must answer this question**

Do you give permission to have a Summary Care Record? <i>(Please read the leaflet about this)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	*
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**NATIONALITY AND LANGUAGE (please tick the appropriate box)**

African	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Other	<input type="checkbox"/>
Bangladeshi <u>OR</u> British Bangladeshi	<input type="checkbox"/>	Mixed British	<input type="checkbox"/>	Pakistani <u>OR</u> British Pakistani	<input type="checkbox"/>
British	<input type="checkbox"/>	Other Asian Background	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	Other Black Background	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Other Mixed Background	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>
Indian <u>OR</u> British Indian	<input type="checkbox"/>	Other White Background	<input type="checkbox"/>	Race Not Stated	<input type="checkbox"/>
What is your main language?	<input type="text"/>				
Do you require an interpreter?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, which dialect?	<input type="text"/>	

**SMOKING STATUS (please tick the appropriate box)**

Smoker	<input type="checkbox"/>	X-Smoker	<input type="checkbox"/>	Never Smoked <input type="checkbox"/>
How many cigarettes per day?	<input type="text"/>	When did you stop? (which year)	<input type="text"/>	
Do you want advice on stopping?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

P.T.O

If you are from abroad, date you first entered UK:

How long have you been given permission to stay in this country? \_\_\_\_\_

Verified by passport visa    Yes  No

(please give supporting evidence as this may delay your registration with practice)

## MEDICATIONS

If you are currently taking regular medication please let us have a copy of your ordering slip from your previous doctor.                    **WE CANNOT ACCEPT HAND WRITTEN COPIES**

## ALLERGIES

Are you aware of any allergies you have?

Yes  No  Allergies: \_\_\_\_\_

## DIET

Do you consider your diet to be:                    Healthy                     Moderate                     Poor

## ALCOHOL

Approximately how many units of alcohol do you consume per week? \_\_\_\_\_/per week

UNITS

  
Pint of Regular  
Beer/Lager/Cider  
(3.5%)

  
Alcopop or  
Can of Lager

  
Glass of Wine  
(175ml) (12%)

  
Single Measure  
of Spirits (40%)

  
Bottle of Wine  
(12%)

Please complete this form to the best of your knowledge to help us until we receive your medical records.

If you are interested in improving your health in any way by making lifestyle changes, e.g. stopping smoking, reducing weight, reducing alcohol intake or increasing exercise, please ask to make an appointment with one of our healthcare assistants who will be very happy to help.

**THANK YOU**






## COLLINGWOOD HEALTH GROUP

### New Patient Alcohol Questionnaire

We would be grateful if you could answer the following questions regarding your alcohol consumption. This will help us to identify patients who may be drinking in an unsafe manner and enable us to offer help and advice where appropriate.

Please circle the answer to the **10 questions** then pass the completed questionnaire back to the receptionist with your registration forms.

NAME: \_\_\_\_\_ DoB: \_\_\_\_\_ DATE: \_\_\_\_\_

UNITS	 <b>2</b>	 <b>1.5</b>	 <b>2</b>	 <b>1</b>	 <b>9</b>
	Pint of Regular Beer/Lager/Cider (3.5%)	Alcopop or Can of Lager	Glass of Wine (175ml) (12%)	Single Measure of Spirits (40%)	Bottle of Wine (12%)
Question	(Circle the appropriate answer below)				

Q1. 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	
Q2. How many units of alcohol do you have on a typical day when you are drinking?	1 – 2 units	3 – 4 units	5 – 6 units	7 – 9 units	10+ units	
Q3. How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q4. How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q5. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q6. How often in the last year have you needed an alcoholic drink in the morning to get you going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q7. How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q8. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Q10. Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
	0	1	2	3	4	Your Score
Scoring System						