BELMONT HILL SURGERY
NEW PATIENT QUESTIONNAIRE

Patient Details	
First Name:	Surname:
Middle Name:	Date of Birth:
Address: Postcode:	
Home Telephone No:	Mobile Telephone No:
Email Address:	

Emergency Contact Details	
Name:	
Relationship to the patient:	Contact No:
Is this person your next of kin? Yes ☐ No ☐	May this person be contacted in an emergency? Yes ☐ No ☐

Are you a carer for anyone registered at the practice? Yes ☐ No ☐	Do you have a carer registered at the practice? Yes ☐ No ☐

Patient Ethnicity	
We need to have your ethnicity on record. Please tick the appropriate box which best represents your ethnic group.	
White: a) British ☐ b) Irish ☐ c) Other white background ☐ Mixed: d) White & black Caribbean ☐ e) White & black African ☐ f) White & Asian ☐ g) Any other mixed background ☐ Asian or Asian British: h) Indian ☐ i) Pakistani ☐ j) Bangladeshi ☐ k) Any other Asian background ☐	Black or black British: l) Caribbean ☐ m) African ☐ n) Any other black background ☐ Other ethnic groups: o) Chinese ☐ p) Any other ethnic group ☐ Please specify: …….. q) I refuse to state my ethnicity ☐

What is your first spoken language?	Do you require an interpreter? Yes ☐ No ☐

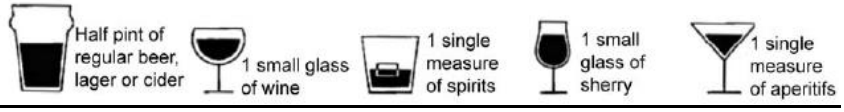
LIFESTYLE QUESTIONNAIRE

Please answer all questions for any patient over 16 years of age.

Smoking	
Do you currently smoke? Yes ☐ No ☐	If so, how many do you smoke per day?
What do you smoke? Cigarettes ☐ Pipe ☐ Cigars ☐ Rolling Tobacco ☐	
Would you like help to quit smoking? Yes ☐ No ☐	
Have you ever smoked? Yes ☐ No ☐	If so, when did you stop?

Drinking						
AUDIT	**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	
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 the last year		Yes, during the 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 the last year		Yes, during the last year	

This is one unit of alcohol...



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