Ashley Surgery- NEW PATIENT QUESTIONNAIRE

Welcome to Ashley Surgery. In addition to the GMS 1 form, please complete the attached questionnaires. The information will be handled confidentially but if you are concerned about any of the questions leave them blank. After completion the questionnaire should be returned to the receptionist.

TODAY'S DATE ....

In a medical emergency who should we contact on your behalf:			
Name			
Address			
Telephone number		**Relationship to you**	
ALLERGIES	**Are you allergic to any medications, substances or foods?**	□ **Yes** □ **No**	**If YES please give details:**

Are you Caring for Someone or does Someone Care for You?

A Carer is a person who is looking after or is responsible for the care of a relative, friend or neighbour who is mentally or physically disabled or whose health is impaired by old age.

Do You have a Carer? **YES / NO** If Yes, please give details about your carer:			**Do You Care for Someone Else Who Can't Manage Without You? YES / NO** If Yes, please give details about the person you care for:
Name:			
Address:			
Telephone Number:			
Relationship to you:			

Please help us update your HEALTH Record:

1	Your Height			
2	Your Weight			
3	Your waist measurement (if known)	cm **OR** inches		
4	Do you smoke? If Yes, a. how many per day? b. for how many years have you smoked? If an ex-smoker, when did you stop? a. when did you stop? b. how many did you smoke? c. for how many years did you smoke?	YES / NO Cigarettes / Cigars per day: ______________ Year stopped:		
5	Do you have a family history (father or brother under 55 years / mother or sister under 65 years) of Heart Disease? YES/NO			
	Do you have a family history of any of the following?			
	Stroke	YES / NO	Cancer	YES / NO
	Raised Blood Pressure	YES / NO	Diabetes	YES / NO

Ashley Surgery

Please complete the form below, using the attached ethnicity/language code list, attached

Please tick the box that applies to you.

WHITE		**ASIAN OR BRITISH ASIAN**		**MIXED**	
British		Indian/British Indian		White and Black Caribbean	
Any other white background – please specify:		Pakistani/British Pakistani		White and Black African	
		Bangladeshi / British Bangladeshi		White and Asian	
		Any other Asian background – please specify:		Any other mixed background – please specify:	
BLACK OR BLACK BRITISH		**OTHER ETHNIC GROUP**			
Black Caribbean / **British Caribbean**		Chinese			
Black African / British African		Other – please specify:			
Any other black background – please specify					

I DO NOT WISH TO ANSWER	
Please state your first language:	

Communication with our patients

We want to get better at communicating with our patients. If you have any information or communication needs we would like to find out how we can help to meet those needs.
For instance, we want to make sure you can read and understand any information we send you, if you find it hard to read our letters or if you need someone to support you at your appointments, please let us know.

Please tell us if you need information in any other format than standard print or if you have any special communication requirements.

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CONFIDENTIALITY OF HEALTH RECORDS

(As per the Caldicott Committee Report on review of Patient Identifiable Information, published in December 1997)

We ask you for information so that you can receive proper treatment. We keep this information, together with details of your care, because it may be needed if we see you again.

Sometimes the law requires us to pass on information, for example, to notify a birth. The NHS Central Register for England & Wales contains basic personal details of all patients registered with a General Practitioner. The Register does not contain clinical information. You have a right of access to your health records.

EVERYONE WORKING FOR THE NHS HAS A LEGAL DUTY TO KEEP INFORMATION ABOUT YOU CONFIDENTIAL.

You may be receiving care from other people as well as the NHS, so that we can work together for your benefit we may need to share some information about you. We only ever use or pass information about you if people have genuine need for it in both your and everyone's interests.

Whenever we can, we shall remove details, which identify you as an individual. Anyone who receives information from us is also under legal duty to keep it confidential. We ensure that we have your written consent when passing medical information to non-medical persons, e.g. solicitor, insurance companies etc.

THE MAIN REASONS FOR WHICH YOUR INFORMATION MAY BE NEEDED ARE:

- Giving you health care and treatment.
- Looking after the health of the general public.
- Managing and planning the NHS, for example:
    - Making sure that our services can meet patient needs in the future
    - Auditing clinical records
    - Preparing statistics on NHS performance and activity
    - Investigating complaints or legal claims
- Helping staff to review the care they provide to make sure it's of the highest standard.
- Training and educating staff (but you can choose whether or not to be involved personally).
- Research approved by the local Research Ethics Committee. (If anything to do with the research would involve you personally, you will be contacted to see if you are willing to be involved first).

Please indicate below whether you are willing for your records to be reviewed by an Authorised person, as appropriate.

I am willing*/not willing* for my records to be reviewed by an Authorised person. I understand that no information will be divulged to anyone else.

Name (please use capitals):	
Date of Birth:	
Signed:	
Date:	

(* Delete as appropriate)

ALCOHOL CONSUMPTION

Name		DOB	

Questions	
Do you drink alcohol?	**YES / NO / NEVER**
If **YES:** Weekly alcohol Consumption.	**…………… Units per week**
If **NO**, have you drunk in the past? If so, how much in an average week?	**…………… Units per week** **Date stopped drinking ……………………..…….**

Fast Alcohol Screening Test (FAST)

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have 8 (men)/6 (women) or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
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	
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	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

If your score is <u>greater</u> than <u>3</u>, please complete the Alcohol Users Audit Questionnaire overleaf.

This brief intervention package is based on the Drink-Less programme originally developed at the University of Sydney as part of a W.H.O. collaborative study.
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UNITS

Pint of Regular Beer/Lager/Cider

Alcopop or Can of Lager

Glass of Wine (175ml)

Single Measure of Spirits

Bottle of Wine

Alcohol Users Audit Questionnaire

Name		DOB	

Questions	Scoring System					Your Score
	0	1	2	3	4	
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	
How many standard units do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
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	
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	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
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	
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	
Have you or someone else been injured as a result of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

Thank you for completing this questionnaire. It will help us to look after you and your family.