**Welcome to South Axholme Practice**

A questionnaire needs to be completed for yourself and each member of your family. Please complete using only **BLACK INK**. If you are taking medication you need an appointment with HCA and GP.

|  |
| --- |
| **Your Registration Appointment is** |
| Day ………………...Date ……………………….Time ………………..... with Healthcare Assistant |
| Day ………………...Date ……………………….Time ………………….. with Doctor |

|  |  |
| --- | --- |
| **Your Details** |  |
| Surname | Date of Birth |
| First name | Home Tel. |
| Address | Mobile Tel. |
|  | Email |
| Postcode | Ethnicity |
| *For practice use:* | Next of Kin |
| *Patient allocated named GP Yes/No* | Relationship |
| *Patient informed of named GP Yes/No* | Contact Tel. |

|  |
| --- |
| **Your Past Medical History** |
| Are you taking any medication or tablets?  If so please list them: |
| Are you allergic to any tablets or medicine?  If so please list them: |
| Have you ever suffered from:  Blood Pressure ❑ Yes ❑ No  Asthma ❑ Yes ❑ No  Heart Problems ❑ Yes ❑ No  Diabetes ❑ Yes ❑ No  Epilepsy ❑ Yes ❑ No  Stroke ❑ Yes ❑ No |
| Have any of your close family had:  A Heart Attack **under** 60 ❑ Yes ❑ No  A Heart Attack **over** 60 ❑ Yes ❑ No  Diabetes ❑ Yes ❑ No  Stroke ❑ Yes ❑ No  Cancer ❑ Yes ❑ No |

|  |  |
| --- | --- |
|  | Have you ever had any operations or serious illnesses in the past? If so please list them: |
|  | Please list any other conditions you feel we ought to know about or which you wish to discuss at your medical |
|  | Are you a veteran of the armed forces?  ❑ Yes ❑ No |
|  | Smoking Status:  Never smoked ❑ Yes ❑ No  Ex-smoker ❑ Yes ❑ No  Date when stopped ……………...................  Current smoker ❑ Yes ❑ No  If yes, how many per day ………………..……  Would you like to stop? ❑ Yes ❑ No |
|  | Height ………………….. metres/feet |
|  | Weight …………………. Kilos/Stone/lbs |
|  | Are you happy for the practice to contact you by text message?  ❑ Yes ❑ No  ***(Please ensure you have detailed your mobile tel. no. above)***  **Would you like to be registered for online access.**  ❑ Yes ❑ No |

**Accessible Information Standard**

Please let us know if you have any information or communication needs by ticking any of the boxes below that may apply or by giving details in the area provided:

Requires information in braille ❑

Requires information using sign language ❑

Uses a BSL interpreter ❑

Requires a communication partner ❑

Uses a communication device ❑

Deaf ❑

Deafblind ❑

Requires information in easy read ❑

Interpreter needed ❑

Medicine labelling in large print required ❑

Using lipreading ❑

Uses notetaker ❑

Please provide any further information you feel is relevant:

……………………………………………………………………………………………………………………………………

**FOR LADIES:**

How many pregnancies have you had? ………………………..

The date of your last cervical smear?…………………………….

Are you using any form of contraception? ❑ Yes ❑ No

**FOR CHILDREN:**

It is a recommendation of the Climbé inquiry that we record the following information:

Name of child’s Primary Carer if **NOT** living with a parent ………………………………………………………

Name of child’s school **if** the child is of school age …………………………………………………………………

Signed………………………………………………………………. Date …………………………………………………………..

Relationship to child……………………………………………………………………………………………………………….

**Please provide the dates of the following immunisations:**

Tetanus, Diptheria + Polio & HIB

1st ……………………………………….. 2nd ……………………………………….. 3rd ………………………………………..

Whooping Cough ........................................Measles, Mumps and Rubella .............................

Pre-School Boosters…………………………………………………

**Please bring your immunisation record card (red book) to your medical**

**Alcohol Consumption**

If you do not wish to inform us of your alcohol consumption please tick here ❑

**This is one unit of alcohol…**

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**…and each of these is more than one unit**

****

**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 SCORE** |  |  |  |  |  |  |

**Scoring:**

A total of 5 or above indicates increasing or higher risk drinking.

**If your score is 5 or above please complete the remaining questions overleaf.**

**SCORE**

**Remaining AUDIT questions**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **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 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 |  |
| **TOTAL SCORE** |  |  |  |  |  |  |

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk,

20+ Possible dependence

**TOTAL = =**

**TOTAL Score =**

AUDIT C Score (page 1) + Score of questions above