

# CADWGAN SURGERY

## NEW PATIENT QUESTIONNAIRE

This questionnaire has been designed to help us get to know you and your medical history. The information you provide will be treated confidentially.

*Please bring a sample of urine with you to your health check together with proof of your identity eg passport/driver's licence and proof of your address eg utility bill/bank statement.*

Today's date: DD/MM/YY

Personal details	Household Details
MR/MRS/MISS/MS/OTHER	Who lives at home with you? (Please list.)
NAME	Name(s)      Date of birth      Relationship      School/job
PREVIOUS NAME(S)	
MARITAL STATUS	
DATE OF BIRTH	
ADDRESS	
HOME TELEPHONE NUMBER	
MOBILE NUMBER	
Consent for Text message reminder YES/NO	
OCCUPATION	
Retired/Full-time/Part-time/Unemployed	
Do you have a disability that we need to be made aware of when contacting or visiting the surgery?	
If so, please state	
WHICH ETHNIC GROUP DO YOU BELONG TO? (Please tick one)	
White    Chinese	
Black/Black British    Mixed	
Asian or Asian British	
	Children
	Do you have any children not already listed above?
	Please list their name(s)
	Date of birth
	Address
	School/job





LIFESTYLE

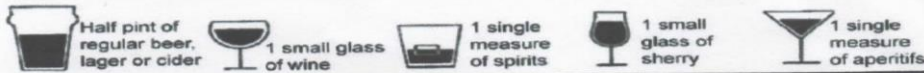
Do you smoke cigarettes/cigars? Yes/no

If yes, how many/day? .....

Are you an ex-smoker? Yes/no

If yes, when did you quit? .....

**This is one unit of alcohol...**



**...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	

**Scoring:**

A total of 5+ indicates increasing or higher risk drinking.  
An overall total score of 5 or above is AUDIT-C positive.



Signature

Relationship to patient ( if not the patient)

Date

FOR OFFICE USE ONLY

Proof of identity: Passport/Driving license/Identity card/Other .....

Proof of Address: Utility Bill/Tenancy Agreement/Bank Statement/Other .....

If aged under 16 years child was accompanied today by .....

Relationship to child .....

Height ..... Weight ..... BP .....

Urine dipstick test result .....

If AUDIT-C score = 5 or more, Full AUDIT screen score=.....