New Patient Health Questionnaire – ADULT

Date completed………………………

Full name……………………………………..………………

Date of Birth ……/……/…… Sex: Male ( ) Female ( )

MEDICAL HISTORY

Do you have any of the following? (Please tick and include details)

ALLERGIES ………………………………………………………………..

MEDICATION ALLERGIES …………………………………………………………………

ASHTMA …………………………………………………………………

DIABETES …………………………………………………………………

SERIOUS ILLNESS …………………………………………………………………

Are you receiving any ongoing medical treatment? YES/NO

If yes, give details of condition treated ………………….........................................................

Are you currently under the care of a Hospital? YES/NO

If yes, please indicate which Hospital and Department/Consultant

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

MEDICATION

Please list all the medication you currently take including dose & strength or provide a copy of your current repeat medication sheet

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

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…………………………………………… ……………………………………………

FAMILY HISTORY

Has any close family had any of the following (please specify family member):

Diabetes………………………………… Asthma………………………………………..

Heart Disease………………………….. High Blood Pressure……………………….

Stroke…………………………………… Tuberculosis…………………………………

Eczema…………………………………. Migraine……………………………………….

Cancer (please specify type)………………………………………………………………………

LIFESTYLE

Alcohol – how many units of alcohol do you drink each week?

1unit = 1 glass wine, ½ pint of beer or single measure of spirit

Units a week………….. Never drink Alcohol…………

Smoking - Do you smoke? Yes / Ex-smoker / Never smoked

If yes what do you smoke? Cigarettes / Cigars/ Pipe

If yes How many per day? .............................................

Exercise - Do you take regular exercise? None/gentle/moderate/vigorous

Diet - What type of diet do you have? (E.g. vegetarian, mixed, low fat, gluten free)

………………………………………………………………………………………………..

What is your approximate Height? ……………………. Weight? ………………….

IMMUNISATIONS (please give the date of last vaccinations)

Tetanus…………………… Polio…………………… BCG……………………..

Any other (including travel vaccinations) ……………………………………………………...

………………………………………………………………………………………………..

………………………………………………………………………………………………..

………………………………………………………………………………………………..

**Female patients only**

Current method of contraception…………………………………………………………………

Date of last smear………………………………… Result….................................................

Have you ever had an abnormal smear YES/NO

Are you taking HRT?............................................................................................................

(please specify type, dose and starting date)

Have you had a mammogram?..............................................Result……………………………….

Updated 02.05.2017

**FAST QUESTIONNAIRE**

**For the following questions please tick the answer which best applies:**

**1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| MEN: How often do you have EIGHT or more drinks on one occasion?  WOMEN: How often do you have SIX or more drinks on one occasion? |  | **Never**  **0** | | **Less than monthly**  **1** | | **Monthly**  **2** | **Weekly**  **3** | **Daily or almost daily**  **4** | | |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? |  | **Never**  **0** | | **Less than monthly**  **1** | | **Monthly**  **2** | **Weekly**  **3** | **Daily or almost daily**  **4** | | |
| How often during the last year have you failed to do what was normally expected of you because of drinking? |  | **Never**  **0** | | **Less than monthly**  **1** | | **Monthly**  **2** | **Weekly**  **3** | **Daily or almost daily**  **4** | | |
| In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? |  | **No**  **0** | | **Yes, on one occasion**  **2** | | **Yes, on more than one occasion**  **4** |  |  | | |
| Total for Each Column: | | |  | |  | |  |  | |
| Total: | | |  | | | | | |  |