Market Square Surgery New Patient Questionnaire

Please take time to complete the questionnaire as fully as possible

Title:	First Name:	Surname:	
Date of birth:	Home Tel:	Mobile Tel: *Please advise the surgery if your mobile number changes	
Do you give consent to receive texts/emails from us? YES/NO *You will routinely receive texts regarding appointments and Health Check Reviews		Do you have any disabilities, sensory loss or communication needs? If so please detail below:	
Work Tel:	NHS No:		Gender M/F:
Email address:	Main spoken language:		Interpreter required:
Marital Status:	Please state religion:		

Ethnicity: (please tick one)

White (UK)	White (Irish)	Indian	Pakistani	Bangladeshi	Other Asian Background
Caribbean	African	Other Black Background	Chinese	Other	Other Mixed Background

Never smoked	Yes		
Are you currently a smoker?	Yes	No	If so, how many cigarettes do you smoke a week?
Ex-Smoker	Yes	No	
Would you like to stop smoking?	Yes	No	If yes please ask about local smoking cessation services.

Please state any allergies: _____

Next of Kin Emergency Contact:

Name:	Address:	Relationship:
Home Tel:	Mobile No:	Work Tel:

Are you a carer? Y/N If yes please provide details of the person you care for:	Do you have a carer? Y/N If yes please provide the name of your carer:

Patient signature: _____ Date: _____

All new patients are asked to make an appointment for a new patient check with our nurse.

THE MARKET SQUARE SURGERY, WALTHAM ABBEY, ESSEX.
AUDIT - The Alcohol Use Disorders Identification Test

Date of doing this test ----------

	0 points	1 point	2 points	3 points	4 points	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many standard drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or Almost Daily	
AUDIT-C TOTAL SCORE OUT OF 12 PROCEED ONLY IF POSITIVE	**A Score of 5 or more is positive** **PROCEED ONLY IF POSITIVE**					
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	
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or Almost Daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or Almost Daily	
7. 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	
8. 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	
9. Have you or someone else been injured as a result of your drinking?	Never		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	Never		Yes, but not in the last year		Yes, during the last year	
AUDIT TOTAL SCORE OUT OF 40 (all 10 questions)	**Scores of 8 or more are considered an indicator of hazardous and harmful alcohol use – need to see GP.**					