NEW PATIENT INFORMATION QUESTIONNAIRE

<table>
<tr><td colspan="3">Date: Mr/Mrs/Miss/Ms</td></tr>
<tr><td colspan="3">First name: Surname/Previous Surname:</td></tr>
<tr><td colspan="3">Address</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">D.O.B. Tel No: Home: Work: email address:</td></tr>
<tr><td colspan="3">Country of Origin: Language Spoken: Occupation:</td></tr>
<tr><td>Do you live in (please tick one)</td><td>Owned house/flat?</td><td>Rented house/flat?</td></tr>
<tr><td></td><td>Staying with friends/relatives?</td><td>Hostel/Refuge</td></tr>
<tr><td></td><td>Sleeping rough?</td><td>Other (please state)</td></tr>
<tr><td colspan="3">Do you look after someone who is ill/disabled/elderly?</td></tr>
<tr><td colspan="3">Are you a Refugee/Asylum Seeker? YES/NO (If yes, we need copies of your papers to go with your registration please)</td></tr>
<tr><td>Next of Kin:</td><td>Relationship:</td><td>Tel No:</td></tr>
<tr><td colspan="3">History: (please state any serious illness/operations/investigations and when)</td></tr>
<tr><td colspan="3">Please state any medication taken:</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Have you any allergies?</td></tr>
<tr><td colspan="3">Do you smoke? YES/NO If yes, how many?</td></tr>
<tr><td colspan="3">Have you ever smoked? YES/NO If yes, how much did you smoke?</td></tr>
<tr><td colspan="3">How much alcohol do you consume per week?</td></tr>
<tr><td colspan="3">What sort of diet do you take?</td></tr>
<tr><td colspan="3">FAMILY HISTORY: Have any of your blood relations suffered from the following and if so, who:</td></tr>
<tr><td colspan="3">Heart Attack: Stroke: High Blood pressure:</td></tr>
<tr><td colspan="3">Diabetes: Asthma: Tuberculosis:</td></tr>
<tr><td colspan="3">Epilepsy: Any type of cancer:</td></tr>
<tr><td colspan="3">Have you had any of the following vaccinations, and when?</td></tr>
<tr><td>Polio YES/NO</td><td>Tetanus YES/NO</td><td>BCG YES/NO</td></tr>
<tr><td>MMR YES/NO</td><td>Measles YES/NO</td><td>Rubella YES/NO</td></tr>
<tr><td colspan="3">FOR FEMALE PATIENTS</td></tr>
<tr><td colspan="3">Have you and any children? YES/NO How many?</td></tr>
<tr><td colspan="3">Do you use contraception? YES/NO If so, which method?</td></tr>
<tr><td colspan="3">Date of last breast screening? (women aged over 50)</td></tr>
<tr><td colspan="3">Date of last cervical smear result</td></tr>
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Fast Alcohol Screening Test (FAST)

For the following questions please circle the answer which best applies.

1 drink = ½ pint of beer or 1 glass of wine or 1 single spirit

1 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	Less than monthly	Monthly	Weekly	Daily or almost daily

2 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

3 How often during the last year have you failed to do what was normally expected of you because of drinking?

Never	Less than monthly	Monthly	Weekly	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	Yes, on one occasion	Yes on more than one occasion