CHURCHILL MEDICAL CENTRE
New Patient Questionnaire

Personal Details

Surname		Title	
First Names		Date of Birth	
Address		Marital Status	
		Occupation	
		Ethnic Origin	
Postcode		Place of Birth	
Telephone numbers:			
Home	Mobile	Work	

Personal Medical History

Have you had any of the following? Please tick

☐ Hay Fever	☐ Asthma	☐ Angina	☐ High Blood Pressure
☐ Diabetes	☐ Heart Attack	☐ Glaucoma	

Please list any other major illnesses or operations: ☐ None

Are you taking any medication? (including contraception) ☐ Yes (please list) ☐ No

1	2	3	4
5	6	7	8

Have you ever smoked?	Yes / No	When did you stop?
Do you smoke now?	Yes / No	How many per day?
Do you drink alcohol	Yes / No	How many units a week?
How much do you weigh?		
How tall are you?		

Do you have any allergies - medicines, drugs or dressings? ☐ Yes (please list) ☐ No

If so, what are you allergic to?

Family Medical History

Have any of you family (parents, brothers / sisters) ever had any of the following? (Please tick and state relation)

☐ Cancer If yes, what type of cancer? ____________________

☐ Asthma	☐ Glaucoma	☐ High Blood Pressure
☐ Diabetes	☐ Stroke	☐ Heart Attack/Angina before the age of 60

Children under 6:

Please complete dates for <u>all</u> vaccinations below

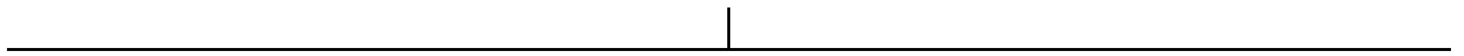
1st Dip/Tet/Pert/Hib/Polio
1st Pneumococcal
2nd Dip/Tet/Pert/Hib/Polio
1st Meningitis C
3rd Dip/Tet/Pert/Hib/Polio
2nd Meningitis C
2nd Pneumococcal
Hib/Men C Booster
1st MMR + Pneumococcal
2nd MMR
Pre-school Booster

Women Only

What was the date of your last smear?

Result:

Where was this taken?



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How Did You Hear About Us?

Please tick one of the following options: (√)

No	OPTION	Tick
1	Primary Care Support Service (PCSS)	
2	Friend / Family Recommendation (Word of Mouth)	
3	NHS.UK Website	
4	Internet Search, i.e google, etc	
5	Churchill Poster	
6	NHS logo, Building Premises	
7	Advert in Newspaper	
8	Other (please describe below)	

Patient Name................................

Patient Date of Birth........................

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 - 8	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.

Only patients over 18 to complete