**Welcome to Ullapool Medical Practice. It can take several weeks to receive your medical record from your previous Dr. It would be helpful to your care if you could complete the questionnaire below, to provide us with some information regarding your personal details and medical history.**

**Please complete as much of this form as possible.**

**If particular questions do not apply to you, please ignore them.**

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| **New Patient Health Questionnaire** | | | | | | | | | | | | | | | |
| **TITLE:** | |  | | | | **FIRST NAME:** | | | |  | | | | | |
| **SURNAME:** | | |  | | | | | | | | | | | | |
| **Name by which you would prefer to be known if different to above:** | | |  | | | | | | | | | | | | |
| **DATE OF BIRTH:** | | |  | | | | | **GENDER:** | | | | **M**  **F**  **other** (please tick) | | | |
| **ADDRESS:** | | | | | | | **WHO ELSE LIVES IN THIS HOUSEHOLD?** | | | | | |  | | |
|  | | | | | | |
| **ARE YOU A CARER FOR SOMEONE?**  **If yes, please specify:** | | | | | | YES  NO  (please tick) | | |
| **HOME TEL:** |  | | | **WORK TEL:** | | |  | | | | **MOBILE TEL:** | | |  | |
| **EMAIL ADDRESS:** | | | | |  | | | | | | | | | | |
| **DO YOU CONSENT TO US SENDING YOU TEXT MESSAGES AND/OR EMAILS?** | | | | | YES  NO  (please tick) | | | | | | | | | | |
| **CAN WE LEAVE VOICEMAILS MESSAGES ON THE FOLLOWING NUMBERS?** | | | | | **HOME TEL:** | | | | | YES  NO  (please tick) | | | | | |
| **MOBILE TEL** | | | | | YES  NO  (please tick) | | | | | |
| **NEXT OF KIN:**  **(Name, Address, Tel No.)** | | | | |  | | | | | | | | | | |
| **HAVE YOU BEEN A MEMBER OF THE UK ARMED FORCES FOR AT LEAST ONE DAY?** | | | | | **YES**   **NO** | | | | **IF YES, SERVICE NO:** | | | | | |  |
| **DATE STARTED/LEFT:** | | | | | |  |

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| SMOKING HABIT | | | | | |
| Current Smoker | | Ex Smoker | | Never Smoked | |
| **Less than 1 per day**  **Please tick** |  | **Have you ever smoked?**  **Please tick** |  | **I have never smoked**  **Please tick** |  |
| **1-9 per day** |  | **If yes, what year did you stop?** |  |  |  |
| **10-19 per day** |  | **How many *did* you smoke per day?** |  |  |  |
| **20-39 per day** |  |  |  |  |  |
| **Over 40 per day** |  |  |  |  |  |
| **Pipe tobacco per week? (oz / grams)** |  |  |  |  |  |
| **Would you like help to stop?** | **YES**   **NO** | | |

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| **ALCOHOL INTAKE** (please tick) | |
| 1 unit = 1 small glass of wine **or** 1 single measure of spirit **or** one half pint of (standard strength) beer | |
| **Do you drink alcohol?** | **YES  NO** |
| **If Yes: Wines / Spirits: units per week** |  |
| **Beer: units per week** |  |
| **TOTAL units per week** |  |

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| **EXERCISE HABIT** (please tick) | |
| **Exercise is physically impossible for me** |  |
| **I avoid even trivial exercise** |  |
| **I enjoy light exercise** |  |
| **I enjoy moderate exercise** |  |
| **I enjoy heavy exercise** |  |

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| **MEDICATION** (please tick) | |
| **ARE YOU ON ANY REGULAR or REPEAT MEDICATION?** | **YES  NO** |
| If yes, please state name and dose, if you have a prescription reorder form from your previous doctor, please hand in a copy with your registration forms | |
| **ARE YOU ALLERGIC TO ANY MEDICINES?** | **YES  NO** (please tick) |
| **ARE YOU ALLERGIC TO ANY NON MEDICINES?** | **YES  NO** (please tick) |
| **If Yes, please tell us the name of the medicine and the nature & severity of the reaction:** | |

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| WOMEN ONLY (please tick) | | | | | |
| **Date of Last Smear?** |  | **What was the Result?** |  | **Where was it taken?** |  |
| **Do you have a coil or implant and if so what date is it due to be replaced** | | | **YES  NO  date:** | | |
| **Do you take the contraceptive pill? If so which one** | | | **YES  NO  name:** | | |
| **Have you had a hysterectomy?** | | | **YES  NO** | | |
| **What was the date of your last mammogram and result?** | | | **Date: Result:** | | |
| **Are you pregnant? If so, what is your due date** | | | **YES  NO  EDD:** | | |
| **Please list any previous pregnancies** | | | **No of births:**  **No of miscarriages:** | | |

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| **FAMILY HISTORY** (please tick) | | | | | |
| **Has a close relative (parent or sibling) suffered from any of the following conditions?** (please tick) | | | | | |
| **Stroke** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Heart Disease inc heart attack and angina** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Diabetes** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Asthma/COPD** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **High blood pressure** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Thyroid disorder** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Bowel Cancer** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Breast Cancer** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Cervical Cancer** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Other cancer, please specify** | **YES  NO** | **Who?** |  | **At what age?** |  |
| **Do any other illnesses run in your family? YES  NO**  **If Yes, Please give details:** | | | | | |

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| |  | | --- | | OTHER INFORMATION |   **MAIN SPOKEN LANGUAGE:**  **IS THERE ANYTHING ELSE YOU FEEL WE SHOULD BE AWARE OF:** |
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| **Date Form Completed:** |  |

Thank you for completing our questionnaire

**NHS Highland FAST Questionnaire**

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

1. MEN: How often do you have EIGHT or more units on one occasion?

WOMEN: How often do you have SIX or more units on one occasion?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. 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?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. 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?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. 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?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily

Record total score here.

**Score 0-2 (Negative)**

No further exploration required unless the patient voices concerns about their alcohol use

**Score 3-7 (Positive)**

Highlight positive screening result. This does not mean that the patient necessarily has an alcohol “problem”. Request patient permission to explore alcohol use further and provide a brief intervention if they are agreeable.

**Score 7+**

If the score is more than 7 consider proceeding to the AUDIT questionnaire which may help to identify dependent drinkers who could benefit from referral to specialist services