PROOF OF ID SEEN: Yes: No: Patient ID No:

COLLINGWOOD HEALTH GROUP – NEW PATIENT QUESTIONNAIRE

Questions in shaded boxes must be answered

YOUR DETAILS			
Surname:		Date of Birth:	
First Name(s):			
Previous Surname:			
Tel: (Home)			
Tel: (Mob)			
Do you wish to opt out of receiving SMS messages?	Yes ☐ No ☐		
Do you wish to opt out of receiving email notifications?	Yes ☐ No ☐		
Are you currently employed?	Yes ☐ No ☐		
If yes, your occupation:			
Are you a carer?	Yes ☐ No ☐	If yes, who for:	
Do you have a nominated Pharmacy?	Yes ☐ No ☐	Would you like to keep this?	Yes ☐ No ☐
Would you like to nominate a Pharmacy?	Pharmacy Name and address:		
Do you take any regular medication? Yes ☐ No ☐ **YOU MUST ENSURE YOU HAVE A MINIMUM OF 1 MONTH SUPPLY OF YOUR MEDICATION BEFORE REGISTERING WITH US**			
Tel: (Work)	Marital status:		
Email:			

Do you have problems with:	Your sight? Yes ☐ No ☐ If Yes, do you require assistance with this? Yes ☐ No ☐
	Your hearing? Yes ☐ No ☐ If Yes, do you require assistance with this? Yes ☐ No ☐

NEXT OF KIN DETAILS			
Title:		Address:	
First Name:			
Surname:		(Home)	
Relationship to you:		(Mob)	
		Can we discuss your record with them? Yes ☐ No ☐	

SUMMARY CARE RECORD (SCR) – If you are over 16 you must answer this question	
Do you give permission to have a Summary Care Record? *(Please read the leaflet about this)*	Yes ☐ No ☐ ✹

NATIONALITY AND LANGUAGE (*please tick the appropriate box*)

African		Irish		Other	
Bangladeshi OR British Bangladeshi		Mixed British		Pakistani OR British Pakistani	
British		Other Asian Background		White and Asian	
Caribbean		Other Black Background		White and Black African	
Chinese		Other Mixed Background		White and Black Caribbean	
Indian OR British Indian		Other White Background		Race Not Stated	
What is your main language?					
Do you require an interpreter?	Yes ☐ No ☐	If yes, which dialect?			

PROOF OF ID SEEN: Yes: No: Patient ID No:

If you are from abroad, date you first entered UK: | | | |

How long have you been given permission to stay in this country? _____

Verified by passport visa Yes ☐ No ☐

(please give supporting evidence as this may delay your registration with practice)

MEDICATIONS

If you are currently taking regular medication please let us have a copy of your ordering slip from your previous doctor. **WE CANNOT ACCEPT HAND WRITTEN COPIES**

ALLERGIES

Are you aware of any allergies you have?

Yes ☐ No ☐ Allergies: _____

DIET

Do you consider your diet to be: Healthy ☐ Moderate ☐ Poor ☐

ALCOHOL

Approximately how many units of alcohol do you consume per week? _____/per week

UNITS

Pint of Regular Beer/Lager/Cider (3.5%)

Alcopop or Can of Lager

Glass of Wine (175ml) (12%)

Single Measure of Spirits (40%)

Bottle of Wine (12%)

SMOKING STATUS (*please tick the appropriate box*)

Smoker	☐	X-Smoker	☐	Never Smoked	☐
How many cigarettes per day?		When did you stop? (which year)			
Do you want advice on stopping?	Yes ☐ No ☐				

Please complete this form to the best of your knowledge to help us until we receive your medical records.

If you are interested in improving your health in any way by making lifestyle changes, e.g. stopping smoking, reducing weight, reducing alcohol intake or increasing exercise, please ask to make an appointment with one of our healthcare assistants who will be very happy to help.

PROOF OF ID SEEN: Yes: No: Patient ID No:

THANK YOU

Patient ID No: _____

COLLINGWOOD HEALTH GROUP

New Patient Alcohol Questionnaire

We would be grateful if you could answer the following questions regarding your alcohol consumption. This will help us to identify patients who may be drinking in an unsafe manner and enable us to offer help and advice where appropriate.

Please circle the answer to the **10 questions** then pass the completed questionnaire back to the receptionist with your registration forms.

NAME: _____ DoB: _____ DATE: _____

UNITS

Pint of Regular Beer/Lager/Cider (3.5%)

Alcopop or Can of Lager

Glass of Wine (175ml) (12%)

Single Measure of Spirits (40%)

Bottle of Wine (12%)

Question	*(Circle the appropriate answer below)*					
Q1. How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
Q2. How many units of alcohol do you have on a typical day when you are drinking?	1 – 2 units	3 – 4 units	5 – 6 units	7 – 9 units	10+ units	
Q3. How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q4. How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q5. How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q6. How often in the last year have you needed an alcoholic drink in the morning to get you going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q7. How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q8. How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Q9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Q10. Has a relative / friend / doctor / health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	
	0	**1**	**2**	**3**	**4**	**Your Score**
	Scoring System					

Scoring – (0-7 Lower Risk) – (8-15 Increasing Risk) – (16-19 Higher Risk) – (20+ Possible Dependence)