The Alresford Surgery

Station Road
ALRESFORD
Hampshire
SO24 9JL
Telephone: 01962 732345

It can often take many weeks before the records arrive from your previous doctor. To help us until then please fill in the form below as honestly and completely as you can.
This is in the strictest confidence.

DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS? YES / NO	
If Yes (tick as appropriate)	Sign Language
	Large Print
	Other

Personal Details			
Sex	Male / Female	DOB	
Title			
Forenames			
Surname			
Address			
Telephone number (home)			
Telephone number (work)			
Telephone number (mobile)		I give consent for communication to be received by SMS text messaging Yes/No	
Email address		I give consent for communication to be received by SMS text messaging Yes/No	
Name of next of kin and telephone number.			
Name and address of last doctor			
Ethnic origin	White – British/Irish/Scottish/other white ethnic group Black – British/Caribbean/African/other (please specify) Indian Pakistani Chinese Other ethnic (non mixed – please specify) Other ethnic (mixed – please specify) Irish traveller Other Asian (please specify)		

Language	Other (please specify) Declaration refused My first language is .....
Health Questionnaire **Please complete or tick or circle the most appropriate statement.**	
Smoking	I have never smoked. I gave up smoking years ago I smoke cigarettes per day. I smoke cigars per day. I smoke oz pipe tobacco per day.
Family history Please tick those which apply to any of your family members.	Angina or heart attack before the age of 60. Angina or heart attack after the age of 60. High blood pressure. Stroke.
Exercise (per week)	No moderate or vigorous activity of 20minutes duration. 1-4 occasions of mixed moderate/vigorous activity. 5-11 occasions of mixed moderate/vigorous activity. 12 or more occasions of moderate activity. 12 or more occasions of mixed moderate/vigorous activity. 12 or more occasions of vigorous activity
Drugs and medicines	Please list any medicines including tablets, capsules, inhalers, creams, contraceptive pill etc you are using, including the name and the dosage.
Allergies	Please list any medications you are allergic or sensitive to.
Immunisations	Have you had a tetanus injection in the last ten years? Yes / No And what was the year of your last injection?
Women only	Have you ever had a cervical smear? Yes / No If Yes, please give the date of your last smear. And was this carried out at your GP's surgery? Yes / No Have you ever been pregnant? Yes / No If yes, how many times? Have you been immunised against Rubella? Yes / No
Thank you for completing this form for our records. All new patients over 6 years of age are invited to have an introductory health check. However, this offer is only open for three months! Please make an appointment with a doctor at your earliest convenience and please bring a small urine sample with you to your appointment.	

Alcohol Questionnaire

Questions	Scoring System					Your Score
	0	1	2	3	4	
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	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If your score is more than 5 please complete the next section.

Alcohol Users Disorders Identification Test (AUDIT)

Questions	Scoring System					Your Score
	0	1	2	3	4	
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	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
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	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
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	
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	
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	
Has a relative, friend, doctor or 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	

Scoring: 0-7=Sensible drinking, 8-15=hazardous drinking, 16-19=harmful drinking, 20+=possible dependency