

**Confidential Health Questionnaire for new patients of BUMS**  
**All information will be treated in the strictest confidence. Thank you.**

|  |   |
|--|---|
| <p>Name: .....</p> <p>Address .....</p> <p>Postcode:.....</p> <p>Telephone Home: ..... Work: .....</p> <p>Mobile Number .....</p> <p>e-mail address: .....</p> <p>Consent to receive SMS text messages from Practice:<br/>         YES/NO</p> <p>Consent to receive e-mails from the practice YES/NO</p> <p>This may include health information, invitations to become members of patient participation groups, etc.</p> | <p>Date of Birth .....</p> <p>Course: .....</p> <p>No. of years .....</p> <p>Name of Emergency Contact .....</p> <p>Relationship:.....</p> <p>Contact No: .....</p> |
|--|---|

Marital Status: Single / Married / Cohabiting / Separated / Divorced / Widowed.

Ethnicity (please tick as appropriate):

|                                |                          |  |                          |
|--------------------------------|--------------------------|--|--------------------------|
| 9i0 British                    | <input type="checkbox"/> | 9i8 Pakistani or British Pakistani     | <input type="checkbox"/> |
| 9i1 Mixed British              | <input type="checkbox"/> | 9i9 Bangladeshi or British Bangladeshi | <input type="checkbox"/> |
| 9i2 Other White Background     | <input type="checkbox"/> | 9iA Other Asian Background             | <input type="checkbox"/> |
| 9i3 White & Black Caribbean    | <input type="checkbox"/> | 9iB Caribbean                          | <input type="checkbox"/> |
| 9i4 White & Black African      | <input type="checkbox"/> | 9iC African                            | <input type="checkbox"/> |
| 9i5 White & Asian              | <input type="checkbox"/> | 9iD Other Black Background             | <input type="checkbox"/> |
| 9i6 Other Mixed Background     | <input type="checkbox"/> | 9iE Chinese                            | <input type="checkbox"/> |
| 9i7 Indian or British Indian   | <input type="checkbox"/> | 9iF Other                              | <input type="checkbox"/> |
| 9iG Ethnic Category Not Stated | <input type="checkbox"/> |  | <input type="checkbox"/> |

IF YOU DO NOT WISH TO PROVIDE US WITH YOUR ETHNICITY, PLEASE TICK HERE

Please describe your first language: .....

| <b>Personal Medical History</b>  |      |
|--|------|
| Please detail any serious or chronic illnesses, operations or disabilities:  |      |
| Details  | Date |
|  |      |
| <b>Family Medical History</b>  |      |
| Have any of your close relatives (parents, brothers, sisters) suffered from any significant medical problems? YES/NO<br>If yes, please detail problem, age of onset and relationship to you: |      |
|  |      |

| <b>Medication:</b>   |  |
|--|--|
| Are you allergic to anything?  | YES/NO      If YES, please detail below: |
|  |  |
| Do you take any drugs, medicines or contraceptive pills? YES/NO                                      |  |
| If Yes, you will need to make an appointment to see the doctor before your next prescription is due. |  |
|  |  |

| HEIGHT                           | WEIGHT |    |
|----------------------------------|--------|----|
| Do you take any exercise?        | Yes    | No |
| Please detail type and frequency |        |    |
|                                  |        |    |

| Lifestyle  |                |   |   |   |   |            |
|--|----------------|---|---|---|---|------------|
| Do you smoke?  | Yes / No       |   |   |   |   |            |
| How many cigarettes / ozs tobacco a day?   |                |   |   |   |   |            |
| Have you ever smoked?  | Yes / No       |   |   |   |   |            |
| When did you give up?  |                |   |   |   |   |            |
| Do you drink alcohol?  | Yes / No       |   |   |   |   |            |
| Average amount per week  |                |   |   |   |   |            |
| Pints of beer:   | Qty            |   |   |   |   |            |
| Glasses of wine:   | Qty            |   |   |   |   |            |
| Measures of spirits:   | Qty            |   |   |   |   |            |
| <b>Measure of Units:</b>   |                |   |   |   |   |            |
| Pint of regular lager/beer/cider = 2 units      Single measure of spirits = 1 unit<br>Alcopop or can of lager = 1.5 units      Bottle of wine = 9 units<br>Glass of wine (175ml) – 2 units |                |   |   |   |   |            |
| Question   | 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/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 and 20+ = Possible dependence

Many thanks for completing this questionnaire.