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

Name:
……
……

Address
……
……..

……
……..

……
Postcode:……

Telephone Home: …… Work:
…..……..

Mobile Number
:……
……..

e-mail address:
……
…….

Consent to receive SMS text messages from Practice:
YES/NO
Consent to receive e-mails from the practice YES/NO

This may include health information, invitations to become members of patient participation groups, etc.

Date of Birth
……
……...

Course:
……
…….

No. of years
……
…….

Name of
Emergency Contact
……..……..

Relationship:……
……

Contact No:
…….
……..

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

Ethnicity (please tick as appropriate):

9i0 British	☐	9i8 Pakistani or British Pakistani	☐
9i1 Mixed British	☐	9i9 Bangladeshi or British Bangladeshi	☐
9i2 Other White Background	☐	9iA Other Asian Background	☐
9i3 White & Black Caribbean	☐	9iB Caribbean	☐
9i4 White & Black African	☐	9iC African	☐
9i5 White & Asian	☐	9iD Other Black Background	☐
9i6 Other Mixed Background	☐	9iE Chinese	☐
9i7 Indian or British Indian	☐	9iF Other	☐
9iG Ethnic Category Not Stated	☐		

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

Please describe your first language: …….

Personal Medical History

Please detail any serious or chronic illnesses, operations or disabilities:

Details	Date

Family Medical History

Have any of your close relatives (parents, brothers, sisters) suffered from any significant medical problems? YES/NO

If yes, please detail problem, age of onset and relationship to you:

Medication:

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

Measure of Units:

Pint of regular lager/beer/cider = 2 units
Alcopop or can of lager = 1.5 units
Glass of wine (175ml) – 2 units
Single measure of spirits = 1 unit
Bottle of wine = 9 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.