Oak Glen Surgery: New Patient Questionnaire

Name _____ **Date of Birth** _____

Smoking Status Never Smoked ☐ Non Smoker ☐ Ex Smoker ☐

Smoker ☐ When Stopped _____

Number of cigarettes per day ☐ Cigar Smoker ☐ Pipe Smoker ☐

Would like to Stop Smoking? ☐

Alcohol Consumption

1. How often do you have a drink containing alcohol?	☐ N/A ☐ Never ☐ Monthly or less ☐ 2 – 4 times per month ☐ 2-3times per week ☐ 4 + times per week
2. How many units of alcohol do you drink on a typical day when you are drinking?	☐ N/A ☐ 1 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐ 10+
3. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	☐ N/A ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly

Exercise

- Unable to Exercise ☐
- Avoid Exercise ☐
- Frequent Light Exercise ☐
- Frequent Moderate Exercise ☐
- Frequent Heavy Exercise ☐

Do you care for someone else? Yes ☐ No ☐ Are you cared for by someone else? Yes ☐ No ☐

If so who – eg. Spouse, Mother, Father **Please enter their relationship not name** _____

Ethnic Origins eg

- White British ☐
- Black African ☐
- White European ☐
- Black Caribbean ☐

Other Other _____

Religion eg

- Church of England ☐
- Roman Catholic ☐

Other _____

Language Spoken _____ **English Speaker** ☐ **Interpreter Required** ☐

Allergies & Medicine Allergies _____

Current Medication _____

Family History

- Asthma ☐
- Diabetes ☐
- Cardiovascular Disease ☐
- Family History of Cancer ☐
- Family history of stroke ☐
- Hypertension ☐
- Thyroid Disorder ☐
- Other conditions relevant ☐

(please specify) _____

Thank you for completing this Questionnaire