



NEW PATIENT QUESTIONNAIRE

Name Date of Birth
Address Post Code
Contact Nos Email Address

NEXT OF KIN

Name Relation
Address
Contact Nos Email Address

SMOKING STATUS

Non Smoker Number per day: 1-9 10-19 20-39 40+
Ex-smoker Date ceased: Please tick above how many you used to smoke. Would you like help to stop smoking YES/NO

ALCOHOL STATUS (1 unit = 1/2 pint beer, lager, cider, 1 single spirit, 1 small glass of wine)

Teetotaller Light drinker: Less than 1 unit daily/1-6 units weekly
Moderate drinker: 1-2 units daily/7-14 units weekly
Heavy drinker: 3-6 units daily/21-42 units weekly
Very heavy drinker: 7-9 units daily/49-63 units weekly

Stopped Drinking: Date ceased: Please tick above how much you used to drink.

EXERCISE STATUS

No Exercise Avoid even trivial exercise Unable to exercise due to health
Light Exercise Moderate Exercise Heavy Exercise Competitive Athlete
Weight and Height if known Weight Height

FAMILY HISTORY Does/did your father, mother, brother or sister suffer form any of the following? Please tick the relevant condition and indicate which relative and age at diagnosis if known. If the relative died of the condition please give age at death if know. NB it is your FAMILY history that is required.

Heart Disease age 60 or under Heart disease age over 60
Diabetes Hypertension/High Blood Pressure
Stroke/TA Hyperlipidaemia/High Cholesterol
Cancer Type

Current Illnesses

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Current Medication

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Benzodiazepine Policy

- * Please note that it is the practice policy that **we do not prescribe regular benzodiazepine medication or sleeping tablets.**
(examples include - Diazepam, Nitrazepam, Temazepam, Zopiclone and Zolpidem)
- * It is our practice policy for **all** new patients to be reviewed.
- * **All** patients (**without exception**) who are taking the above medication will be started on a reduction program until the medication is stopped. This will be done in a controlled way following local health board guide lines.
- * It is the patient’s responsibility to provide evidence of any current medication from their previous practice.

******* By signing the following, you are requesting to join the practice as a patient and are agreeing to comply with the above Benzodiazepine policy if applicable.*******

Signature.....

Name

Date