The Ruddington Medical Centre
Church Street ,Ruddington
Nottingham
NG11 6HD

PATIENT HEALTH QUESTIONNAIRE

Thank you for taking the time to complete this medical questionnaire, the information you provide will help improve our service to you.

First Name		**Surname**	
Title	☐Mr ☐ Mrs ☐ Miss ☐Ms	**Date of Birth**	
Home Address:		**Home Tel**	
		Work Tel	
		Mobile *	
Postcode:		**E-mail:**	

**By giving a mobile number, you consent to receiving communication via text (eg. confirmation of appointments)*

Ethnicity	*If you do not wish to disclose this information please tick box* ☐
White	☐ **British** ☐ **Irish** ☐**Other (please specify)**
Black	☐ **Caribbean** ☐ **African** ☐ **Other (please specify)**
Asian	☐ **Indian** ☐ **Pakistani** ☐ **Chinese Other (please specify)**
Mixed	☐ **White + Black Caribbean** ☐ **White + Black African** ☐ **White + Asian** ☐ **Other (please specify)**

Height and Weight			
What is your height?		**What is your weight?**	

If you still attend Nursery/School, which Nursery/School do you attend?

Are you taking any regular prescribed medication	☐ **Yes** ☐ **No**
If yes, please provide us with repeat prescription slip or medication packets so that we can update your records.	

Are you allergic to any medicines and if so, which?	☐ **Yes** ☐ **No**

Family History					
Do you have a family history (father or brother under 55 years/ mother or sister under 65 years) of any of the following?					
Heart Attack	☐ **Yes**	☐ **No**	**High Blood Pressure**	☐ **Yes**	☐ **No**
Stroke	☐ **Yes**	☐ **No**	**Diabetes**	☐ **Yes**	☐ **No**
Angina	☐ **Yes**	☐ **No**	**Cancer**	☐ **Yes**	☐ **No**

Smoking

Have You ever smoked?	**☐ Yes ☐ No**
Do you currently smoke?	**☐ Yes ☐ No**
If yes to Question 2, please answer the following questions:	
What do you smoke?	**Cigarette [ ] Cigar [ ] Pipe [ ]**
	Electronic [ ] Other_____
How many do you smoke per day?	**_____**
How long have you smoked for?	**_____**
Have you ever considered giving up smoking?	**☐ Yes ☐ No**

If you would like further information on giving up smoking, please contact Manor Pharmacy for more information.

Are you registered disabled? (If yes, please give details)	**☐ Yes ☐ No**

Carers	
Do you have a carer? (If yes please give details)	**☐ Yes ☐ No**
Are you a carer? (If yes please give details)	**☐ Yes ☐ No**

Do you suffer from? (tick appropriate)			
If yes, please make an appointment with the practice nurse for a New Patient Screening Appt.			
Epilepsy	**☐ Yes ☐ No**	**COPD**	**☐ Yes ☐ No**
High Blood Pressure	**☐ Yes ☐ No**	**Diabetes**	**☐ Yes ☐ No**
Heart Attack/ Stroke	**☐ Yes ☐ No**	**Cancer**	**☐ Yes ☐ No**
Asthma	**☐ Yes ☐No**		

If you are 40-74 we would like to invite you for an NHS Health Check. If you would like one of these please make an appointment with our practice phlebotomist for a fasting blood test and then an appointment one week later for a review and feedback of results with the practice nurse.

Your Next Of Kin (1)					
Title:		**Name:**		**Relationship to you:**	
Contact Numbers:					
Address:					
Are you happy for your medical information to be shared with your Next Of Kin?					**Yes / No**

Your Next Of Kin (2)					
Title:		**Name:**		**Relationship to you:**	
Contact Numbers:					
Address:					
Are you happy for your medical information to be shared with your Next Of Kin?					**Yes / No**

Signature	**Date**

TO BE COMPLETED BY PATIENTS AGED 16 AND OVER

QUESTIONNAIRE 1

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL SCORE FOR QUESTIONNAIRE 1						

A total score of 5+ indicates increasing or higher risk drinking.

Only complete the next questionnaire if your score is 5+

QUESTIONNAIRE 2

Questions	Scoring System					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking and suggested that you cut down?	No		Yes but not in the last year.		Yes, during the last year.	
TOTAL SCORE FOR QUESTIONNAIRE 2						

Score from Questionnaire 1

ADD

Score from Questionnaire 2

OVERALL SCORE **=**

OVERALL SCORE

Scoring- YOUR ACTIONS

0-7 **Lower Risk** – for more refer to www.nhs.uk/Livewell/Alcohol OR ask for a leaflet from reception

8-15 **increasing risk** – for more refer to www.nhs.uk/Livewell/Alcohol OR ask for a leaflet from reception.

16-19 **Higher risk** – We recommend that you book an appointment with a GP/Nurse for further advice

20+ **Possible dependence** – Please book an appointment with a GP at your earliest convenience