

Date:.....

Welcome to our Practice

To make sure we provide you with appropriate health care, please complete this form.

We would like to invite you to make an appointment to have a health check with one of our Health Care Assistants. This is particularly useful for patients:

- On regular medication
- Who have one of the conditions listed
- Who are over 40 years of age

I would/would not like a health check (please delete as appropriate)

Name:

D.O.B:

Daytime tel. no:

Sex: **Male/Female** (please delete as appropriate)

Ethnic origin (please tick one):

- | | | | |
|------------------------------------|---------------------------------------|--|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Indian | <input type="checkbox"/> Black African | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Pakistani | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Black Caribbean |
| <input type="checkbox"/> Other | <input type="checkbox"/> Confidential | | |

1st Spoken Language:

Occupation:

Next of kin:

Tel. no. next of kin:

Are you a Carer? **Yes/No**

If so, would you like to be referred to the Carers Support Scheme? **Yes/No**

Do you suffer or have you suffered from any of the following? (Please circle)

- | | | |
|-------------------------|---------------|--|
| *Coronary heart disease | *Hypertension | *Chronic Obstructive Pulmonary disease |
| *Diabetes Mellitus | *Epilepsy | *Hypothyroidism |
| *Asthma | *Cancer | *A mental health problem e.g. depression |

Have you ever had any of the following? (Please circle)

* Heart attack *Stroke * Epileptic fit

What medication do you take?

(Please specify and continue on another sheet of paper if necessary)

.....
.....

Height:cm

Weight:kg

Do you smoke? Yes/No

(Please read the attached leaflet)

If so, how many do you smoke a day?

Have you ever smoked? Yes/No

If so when did you stop?

Scoring system

| Question | 0 | 1 | 2 | 3 | 4 | Your Score |
|--|-------|-------------------|---------------------|--------------------|-----------------------|------------|
| 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 | 2-3 | 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 | |

A score of 5+ indicates hazardous drinking and you will be requested to complete, a further Alcohol Users Disorders Identification Test (Audit), as well as being given self help information on reducing alcohol intake.

Thank you for providing us with this information.