**Chainbridge Medical Partnership**

REGISTRATION QUESTIONNAIRE FOR PATIENTS OVER 16 YEARS

E-Mail Address (this will be used to set up your on-line access to book appointments and order any

medication you take) ……………………………………………………………………………………………………………………………

What is your height? ………………………………………What is your current weight? ……………………………………

What is your first spoken language (e.g. English) ………………………………………………………………………………….

Do you require an interpreter when attending an appointment? .............................................................

What is your ethnicity (e.g. White British) …………………………………………………………………………………………….

Are you a Veteran? (ex-service person)……………………………………………………………………………………………….

Do you have a Partner or Child who is a Veteran? Who? ………………………………………………………………………

Do you smoke? If yes how many, approximately, do you smoke per day? ……………………………………………

Are you a carer? (A carer is someone who, without payment, gives help and support to a person who otherwise may not manage because of their disability, frailty, or illness)

If yes who do you care for? ……………………………….…………………………………..

Do you have any communication needs that the practice should be aware of (e.g. sight or hearing

problems)?…………………………………………………………………………………………………………………………………………….

Do you have any long term conditions (e.g. Asthma, COPD, Heart conditions, diabetes)?…………………….

……………………………………………………………………………………………………………………………………………………………..

If you are on regular medication you will need to tell us which pharmacy you want this to go to when it is due. The practice does not produce paper prescriptions as we operate a fully computerised system.

Name of pharmacy………………………………………………………………………………………………………………………………

**Your NHS Data Matters**

Information about your health and care helps the NHS improve your individual care, speed up diagnosis, plan your local services and research new treatments.

In May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patient information safe and always being clear about how it is used.

You can choose whether your confidential patient information is used for research and planning.

To find out more or to opt-out you must go to the follow website otherwise your information will automatically be entered.

[**www.nhs.uk/your-nhs-data-matters**](http://www.nhs.uk/your-nhs-data-matters)

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…and each of these is more than one unit

This is one unit

of alcohol…

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT** | **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 |  |
| 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 or suggested that you cut down? | No |  | Yes, but not in the last year  **SCORE** |  | Yes, during the last year |  |

**Scoring:** 0–7 = Lower risk, 8–15 = Increasing risk, 16–19 = Higher risk,

20+ = Possible dependence