QUEEN CAMEL MEDICAL CENTRE - GENERAL HEALTH QUESTIONNAIRE

TITLE	MR / MRS / MISS / MS / DR OTHER: _____			
FULL NAME				
PREVIOUS SURNAME *(If Applicable)*		**DATE OF BIRTH**		
PLACE OF BIRTH				
ADDRESS		**POSTCODE**		
TELPHONE NUMBER		**MOBILE NUMBER**		
E-MAIL				

Occasionally we send out our practice newsletter and information about upcoming clinics we may be holding by e-mail/text. We will never share your e-mail/text with any 3rd party without your consent. If you consent to us contacting you for this purpose please circle appropriate box below:

Yes/No I would like to receive communication by e-mail
Yes/No I would like to receive communication by text

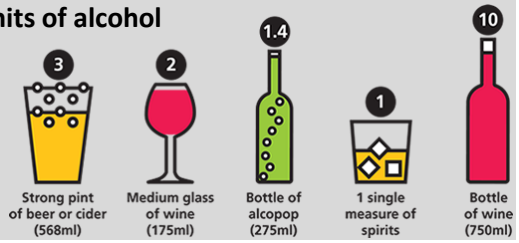
You can order your prescriptions online. If you would like to use this service please tick the box below and we will email you your registration document. You must provide your **own** email address to use this service.

☐ Yes please, I would like to have online patient access
☐ No thank you, I do not wish to have online patient access

ETHNICITY	British or Mixed British	☐	Pakistani or British Pakistani	☐
	Irish	☐	Bangladeshi or British Bangladeshi	☐
	Other White Background	☐	Other Asian Background	☐
	White & Black Caribbean	☐	Caribbean	☐
	White & Black African	☐	African	☐
	White & Asian	☐	Other Black Background	☐
	Other Mixed Background	☐	Chinese	☐
	Indian or British Indian	☐	Other	☐
FIRST LANGUAGE	English Other: _____			
ARE YOU A CARER FOR A FAMILY MEMBER OR FRIEND:	Name of person cared for: Relationship to person cared for:			
HEIGHT		**WEIGHT**		
BLOOD PRESSURE	*(Machine in Waiting Room)* **Systolic** _____ / **Diastolic** _____			
SMOKING STATUS *If you would like help to quit smoking please call 01823 765006 or 0800 2461063 for more details or go to www.smokefreelifesomerset.co.uk*	☐ Never Smoked Tobacco ☐ Current Smoker – _____ per day (please enter number) ☐ Ex-trivial Smoker (<1/day) ☐ Ex-light Smoker (1-9/day) ☐ Ex-moderate Smoker (10-19/day) ☐ Ex-heavy Smoker (20-39/day)				
ALCOHOL CONSUMPTION	How many units of alcohol do you drink in a week: _____ *(A unit of alcohol is half a pint, a glass of wine or a single measure spirit)*				
ALLERGIES					

Turn page to complete questionnaire

AUDIT – C ALCOHOL QUESTIONNAIRE

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	

Scoring:
A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.

If score is more than 5 the questionnaire is complete, please complete the remaining questions.

AUDIT-C SCORE

Remaining AUDIT questions

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 or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:
0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence
TOTAL Score equals = AUDIT C Score (above) + Score of remaining questions
If Total Score is 8 or over, please book an appointment to see the doctor.

TOTAL SCORE