Crawcrook Medical Centre Health Questionnaire (v1.2)

Please complete this form **before** your health check and hand it to the nurse or health care assistant at your health check.

The waiting room has a machine that can be used for your height and weight.

This form is available in large print format

Date:	
Height:	Weight:

Please also provide bring a urine sample in a sterile green topped bottle. These are available from reception and you can use our facilities on site provide us with a sample on the day you attend

Patient Details

Surname:	Forename:
Address: Postcode: Email address: (please write clearly)	Do you consent to the practice using your email to communicate with you* Yes ☐ No ☐ *You can opt out at any time
Home Telephone: Mobile:	Do you consent to the practice using your mobile number to send you texts* Yes ☐ No ☐ *You can opt out at any time

Smoking

Have you ever smoked? ☐ Yes No ☐

If yes, do you still smoke now? ☐ Yes No ☐

How many cigarettes do you/did you smoke daily?:

How many cigars do you/did you smoke daily?:

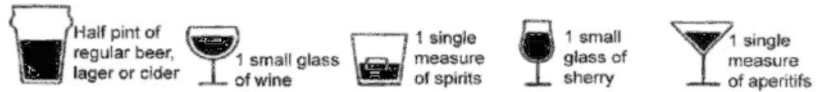
If you smoke roll ups, how many ounces do you/did you smoke daily?:

If you smoke a pipe, how many ounces do you/did you smoke daily?:

How long have you/had you been a smoker?:

If you have quit what year did you quit?:

This is <u>one</u> unit of alcohol…



…and each of these is <u>more</u> than one unit

AUDIT	Scoring system					Your score
	0	**1**	**2**	**3**	**4**	
1.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	
2. 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+	
3. 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	
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	
5. 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	
6. 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	
7. 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	
8. 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	
9. 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	

Audit C SCORE

Office use only

Audit SCORE

For official use only
Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

Diet

You are recommended to:

1. Eat starchy foods (Complex carbohydrates) such as bread, breakfast cereals, potatoes, rice and pasta, and these make up the bulk of your meal
2. 5 portions of fruit and vegetables a day
3. Eat plenty of fibre (roughage). Contained in starchy foods, fruit and vegetables and wholemeal rice, pasta and bread
4. Low fat milk and diary products These are an important source of calcium and vitamins
5. Eat protein foods in moderation Including oily fish
6. Don’t eat too much fat
7. Don’t eat too many sugary foods and drink
8. Don’t eat too much salt

Exercise

Over the week you are recommended to have at least 150 minutes (2 ½ hours) of moderate intensity activity (e.g. brisk walking) in bouts of 10 minutes or more (e.g. 30 minutes five days a week) or 75 minutes of vigorous intensity activity spread across the week

How would you grade your current level of exercise? (please tick)

Impossible to do exercise ☐

Avoids Exercise ☐

Enjoys Light Exercise ☐

Enjoys Moderate Exercise ☐

Enjoys Vigorous Exercise ☐

Family History

Do any of your blood relative have or have had any of the following conditions?

Disease/Condition	Relation to you
Heart Disease – in a male before they reached 55 or female before they reached 65	
Stroke	
Diabetes	
High Blood Pressure	
High Cholesterol	

Well Being

During the last month have you been bothered by feeling down, depressed or hopeless?	☐ Yes No ☐
During the last month have you often been bothered by having little or no pleasure in doing things?	☐ Yes No ☐