

# **Welcome to The New Surgery**

We would like to take this opportunity to welcome you to The New Surgery.

If you are registering with the practice and are between the ages of 40 – 74 years, without any previous medical history of note i.e. No diabetes, cardiovascular disease, etc, we would like you to undertake an NHS health check as part of your registration.

Please do not worry as the results of this check do not mean that we will not register you.

The health check has been designed for patients in the age cohort to help prevent cardiovascular disease from developing.

Please complete the details overleaf and hand into the receptionist. They will check and advise if you need an appointment and help you with your booking.

# ***The New Surgery***

8 Shenfield Road  
Brentwood  
Essex  
CM15 8AB

Tel: 01277 218393 Fax: 01277 201017  
www.thenewsurgery-brentwood.co.uk

Dr A Naeem Dr M Nasif Dr H Qureshi Dr A Guniyangodage Dr S Masuthu Dr T Webb

## Personal Details:

Surname..... Former Surname.....

First Names .....

Address .....

..... Post code.....

Home telephone number..... Mobile ..... SMS consent Y / N

Date of birth..... Occupation .....

Male  Female  Number of children (if any).....

Next of Kin - Name .....Telephone number.....Relationship.....

Ethnic Group: White  Black or Black British  Asian or Asian British  Mixed  Chinese

Other Ethnic Group .....

Are you a Carer? Yes  No

The Name of the person you care for if registered with our surgery.....

Do you have a Carer? Yes  No

Name of Carer..... Contact Number.....

## Exercise Habit:

None  Light  Moderate  Heavy

Daily  Weekly  Occasionally

**Allergies :** None  Drugs  Other  (eg Hayfever, Penicillin)

Please Specify .....

**If known - Height .....** **weight .....**

**Illnesses - do you suffer from**

Diabetes  Type 1 or Type 2 ..... Hypertension   
Epilepsy  Asthma  COPD

**Do you have or have you had:**

Cancer  Please specify ..... Heart Problems  Please specify.....  
Stroke  Glaucoma  Tuberculosis

Any other long term or serious illness.....  
.....

Have your parents, grandparents, brothers, sisters or children ever suffered from any of the illnesses listed above?

Please enter the relationship and the illness.....  
.....

**FEMALES ONLY:**

Type of contraception used .....  
Are you currently pregnant? .....  
Date of last cervical smear .....  
Have you ever had an abnormal smear result? .....  
Number of Pregnancies (please include any miscarriages or terminations).....

**Alcohol: PLEASE ALSO COMPLETE THE ATTACHED FORM**

**Smoking:**

Do you smoke tobacco?

Yes  Cigarettes  Cigars  Roll ups  Pipe

How many each day? .....

For how long have you smoked? .....

Do you wish to stop smoking? Yes  No

**THE PRACTICE OFFER SMOKING CESSATION APPOINTMENTS PLEASE ASK IN THE TREATMENT ROOM**

Are you a former Smoker? Yes  (Please complete below) No

When did you stop?.....

For how long did you smoke?.....

How many per day?.....

**Current medication and dosages (including contraceptive pill) PLEASE PROVIDE A COPY OF YOUR REPEAT PRESCRIPTION FROM YOUR PREVIOUS GP IF POSSIBLE**

.....  
.....  
.....

Date of completing this questionnaire .....

# Alcohol Use Disorder Identification Test – Consumption (AUDIT-C)

WHO designed by [www.effectivepi.co.uk](http://www.effectivepi.co.uk). Free from copyright.



Remember, drinks poured at home are usually bigger

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 - 8	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:

An overall total score of 5 or above is AUDIT-C positive and may indicate hazardous or harmful drinking.



## Score from AUDIT- C (other side)



## 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            Indicates Sensible Drinking (Lower risk)
- 8 – 15         Indicates Hazardous Drinking (Increasing risk)
- 16 – 19        Indicates Harmful Drinking (Higher risk)
- 20+             Indicates Possible Dependence

