**The Lambert Medical Centre, 2 Chapel Street, Thirsk, YO7 1LU**

**Tel. 01845 523157**

To register with the practice please complete this questionnaire as fully as possible. This will assist the doctor and nursing team in providing your care and treatment.

Surname…………………………………………. Forename……………………………………………..

Address………………………………………………………………………………………………………………………...

Postcode…………………………………………………. Date of Birth……………………………………………..

Home tel. number……………………………………. Mobile Number….......................................

Email address………………………………………………………………………………………………………………..

Would you be happy for the practice to contact you via email? Yes [ ]  No [ ]

Would you be happy for the practice to contact you via text message Yes [ ]  No [ ]

**We use these forms of communication for appointment reminders, invites to clinics where appropriate, queries to update your medical records, Surgery Newsletter and information about services we offer.**

**We do not pass these contact details to any third party not involved in your care.**

**\*\* We want to ensure that all your medical information is kept safe and secure therefore it is very important that you advise the practice if any of these details change\*\***

Do you have any special communication needs and are you happy for us to share this with other healthcare providers ? ………………………………………………………………………………………………………………….

**Are you or a member of your family a veteran or current member of the armed forces?**

Please specify:………………………………………………………………………………………………………………..

**Previous Medical History**

Please let us know if you have any of the following conditions:

* Diabetes - Type 1 [ ]  Type 2 [ ]  Not sure [ ]
* COPD [ ]
* Previous Stroke / Transient Ischaemic Attack [ ]
* Chronic Heart Disease [ ]

Are you under hospital supervision or monitoring for any medical conditions. If yes give details:

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

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

**Family History**

Is there any of the following in your immediate family (father, mother, brother, sister):

Heart Disease [ ]  Diabetes [ ]  High Blood Pressure [ ]

Stroke [ ]  High Cholesterol [ ]  Cancer [ ]  (Please specify)

If yes, please give details of whom affected and at what age………………………………………….

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

**Allergies**

Please give details of any known allergies, particularly drug reactions:

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

**Smoking**

Do you smoke? Yes No

If yes, how many cigarettes/cigars/oz of tobacco per day ……………………………………………..

If no, have you ever smoked and when did you give up …………………………………………………

**Carers**

Are you a Registered carer for anyone? If so, please give details…………………………………………………………………

Do you have a registered carer? If so, please give details……………………………………………………………………………..

**Alcohol**

Please circle the relevant answers: Please note that 1 standard drink = ½ pint of beer or lager, a small glass of wine, a single shot of spirit.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **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 perweek | 4+ perweek |  |
| How many standard alcoholic drinks do you have on a typical day? | 1-2 | 3-4 | 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 |  |

  **Please provide your total in this box**

|  |
| --- |
|  |

Please complete the reverse questions only if you scored more than 8 in the previous section

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Your score** |
| How often in the last year have you found you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you failed to do what was expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often in the last year have you not been able to remember what happened when drinking the night before? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or someone 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/ friend/doctor/ health worker been concerned about your drinking or advised you to cut down? | No |  | Yes, but not in the last year |  | Yes, during the last year |  |
|  |  |  |  |  | **Sub Total** |  |
|  |  |  |  |  | **Total**  |  |

We aim to provide lifestyle advice where appropriate. If you would like to speak to someone about your lifestyle or would like advice on giving up smoking or drinking please refer to our website or speak to your GP or nurse who will be able to help.

*Reception Staff: Please tick here and initial if you have given out a lifestyle advice leaflet.* [ ]

 *Please tick here and initial if you have added code 67DJ + 9nn60* [ ]

 *Receive information by phone – 9Nds*

 *Receive information by text – 9Ndp*