



# Avon Valley Practice

## Welcome

Thank you for registering with us. We very much hope that we provide you with convenient and accessible medical services. As part of your registration, please take a few moments to complete the questions below. We would also like to offer you a new patient health check which will provide a good basis for continuing medical care.

This assessment is carried out by one of our nursing team and we would be grateful if you could make an appointment with one of them. Please remember to bring a sample of urine with you.

Please read our practice leaflet and visit our website, [avonvalleypractice.com](http://avonvalleypractice.com), to find out more about the practice. Importantly, you can make appointments and order repeat medication online however you will need to register by asking one of the receptionists to organise access for you.

**Please complete the form below:**

I would like a health check

I would NOT like a health check

**First Name:** .....

**Occupation:** .....

**Surname:** .....

**Height:** .....cm/ft

**D.O.B:** .....

**Weight:** ..... kg/stone

**Home tel. no:** .....

**Do you smoke?** Yes / No

**Mobile tel. no:** .....

**If so how many do you smoke?** .....

**Work tel. no:** .....

**Have you ever smoked?** Yes / No  
**If so when did you stop?** .....

**Sex:** Male / Female

**Are you a carer?** Yes / No

**Ethnic origin (please tick):**

- White, British
- White, other
- Black African
- Pakistani
- Vietnamese
- Indian
- Chinese
- Black Caribbean
- Bangladeshi
- Confidential

**If so, would you like to be referred to the Carers Support scheme?** Yes / No

**Contact details for your Next of Kin**

**Name:** .....

Other.....

**Tel. No:** .....

**First speaking language** .....

**Do you have any allergies** Yes / No  
**If so, what are they?**.....

.....

Please turn over to complete the rest of the questionnaire

If you are 16 years old or over, we have been asked to collect information regarding your alcohol consumption. If you would prefer NOT to answer these questions, please tick

| Questions   | Scoring system |                   |                              |        |                          | Your score |
|---|----------------|-------------------|------------------------------|--------|--------------------------|------------|
|   | 0              | 1                 | 2                            | 3      | 4                        |            |
| How often do you have a drink that contains alcohol?  | Never          | Less than monthly | Monthly                      | Weekly | Daily or almost daily    |            |
| How many standard alcoholic drinks do you have on a typical day when you are drinking?                          | 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    |            |
| 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 |            |

**Do you suffer or have you suffered from any of the following?** (Please circle)

- |                          |                |   |
|--------------------------|----------------|---|
| * Coronary heart disease | * Hypertension | * Chronic Obstructive Pulmonary disease   |
| * Diabetes Mellitus      | * Epilepsy     | * Hypothyroidism                          |
| * Asthma                 | * Cancer       | * A mental health problem e.g. depression |
| * Renal failure          | * Psoriasis    | * Parkinsons disease                      |

**Have you ever had any of the following?** (Please circle)

- |                |          |                 |
|----------------|----------|-----------------|
| * Heart attack | * Stroke | * Epileptic fit |
|----------------|----------|-----------------|

**What medication do you take?** (Please specify). .....

.....

\_\_\_\_\_  
 Patient's signature: .....Date:.....