NEW PATIENT SCREENING QUESTIONNAIRE FOR ADULTS

**** Please make sure all greyed out sections are completed ****

YOUR DETAILS:	
Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Rev ☐ Other	Surname:
Date of Birth:	First Names:

INFORMATION ABOUT YOU:
What is your height?
What is your weight?
What is your first language?
Do you need an interpreter? ☐ Yes ☐ No

SMOKING:	
Do you smoke?	☐ Yes ☐ No
If 'No', have you ever smoked?	☐ Yes ☐ No
Date you approximately gave up:	
If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?	
If you would like advice and support to stop smoking, please make an appointment with the nurse for a smoking cessation appointment.	

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?	1 or 2	3 or 4	5 or 6	7 or 9	10 or more

How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily

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/Almost daily

How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily/Almost daily

How often in 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/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/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/Almost daily

Have you or someone else been injured as a result of your drinking?	No		Yes but not in the past year		Yes, during the past year

Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes but not in the past year		Yes, during the past year

Signature:	**Date:**