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| **The Wycliffe Medical Practice**  **Annual Review Questionnaire** | | | | | |
| In order to provide you with the best possible care, it is helpful if you can provide the following information. | | | | | |
| **Name** | | **Date of Birth** | | **Today’s Date** | |
| **Please fill in this information at home or go to the Health Information Room as soon as you arrive at the surgery:** | | | | | |
| What is your height? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| What is your waist circumference? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Pulse rate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| If you monitor your blood pressure at home, please bring 16 readings done over the course of 8 days as these tend to be more accurate than surgery readings. | | | | | |
| **Is your general health:** | | | | | |
| about the same | getting better | | | | getting worse |
| **Do you smoke?** | | | YES  NO | | |
| If YES – how many cigarettes do you smoke per day? | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| If you do not smoke now, have you ever smoked? | | | YES  NO | | |
| If so, how many did you smoke and when did you stop? | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| We always encourage our patients who smoke to stop smoking.  For help and advice please call Quit Ready Leicestershire on 0345 646 6666 or visit quitready.co.uk | | | | | |
| **Do you ever have a drink that contains alcohol?** | | | YES  NO | | |
| If YES – please complete the alcohol questionnaire on page 2. | | | | | |
| **Do you take ‘over the counter’ Aspirin every day?** | | | YES  NO | | |
| **Over the last two months have you felt depressed or low in mood?** | | | | | |
| Yes. If yes, please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| No. | | | | | |
| **Do you or your family have any concerns about your memory?** | | | | | |
| Yes. If yes, please book an appointment with a doctor. | | | | | |
| No. | | | | | |
| **Do you regularly take aspirin which you have bought over the counter?**  Yes.  No. | | | | | |

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| **Alcohol Questionnaire** | | | | | |
| **If you drink alcohol please answer the following questions.** | | | | | |
| This quesionnaire refers to standard alcoholic drinks.  A standard drink containing one unit of alcohol is:   * ½ a pint of regular beer, lager or cider * 1 small glass of wine * 1 single measure of spirits * 1 small glass of sherry * 1 single measure of aperitifs | | | | | |
| **Questions** | **Answers** | | | | |
| How often do you have a drink that contains alcohol? | Never | Monthly  or less | Once a week | 2-3 times  per week | 4+ times  per week |
| How many standard alcoholic units do you have on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |
| How often do you have 6 or more units on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
|  | | | | | |
| How often in the last year have you found that you were not able to stop drinking once you have 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 or 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 |
|  | | | | | |
| Would you like information or advice about alcohol consumption?  Yes No | | | | | |