



# Ridgmount Practice Registration Form

## Alcohol Consumption Questionnaire

Questions	Scoring System					Your score
	0	1	2	3	4	
1. 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	=
2. How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	=
3. 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	=
<b>If you scored 5 or more please answer Questions 4 to 10.</b>					<b>Total</b>	=
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	=
5. 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	=
6. 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	=
7. 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	=
8. 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	=
9. 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	=
10. Has a relative or friend, doctor or 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	=
<b>TOTAL</b>						=

**38. Are you A Carer or do you have a Carer? I am A Carer                      I Have a Carer                      Not applicable**

**39. Details of Carer/Person you Care for: Relationship:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **Family Name:** \_\_\_\_\_ **Given Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

### Gynaecological Examination to detect pre-cancer cells/Smear Test/Pap Smear/ 子宫颈抹片检查,可以早期侦测子宫颈癌

**40. Date of last Cervical Smear? (PAP Test)** \_\_\_\_/\_\_\_\_/\_\_\_\_

**41. Where was it taken? GP Surgery**  (GMS another practice) **Other UK Clinic/Hospital**  (Not GMS) **Abroad**  (Not GMS)

**42. Cervical Smear Result:** Negative/Normal  Abnormal  Details \_\_\_\_\_

### 43. Please complete dates of Immunisations

Immunisation	Date	Immunisation	Date
a. Meningitis ACWY	____/____/____	c. 1 <sup>st</sup> MMR	____/____/____
b. Meningitis C	____/____/____	d. 2 <sup>nd</sup> MMR	____/____/____

**Please read the following important information**  
 We recommend HIV testing for all new patients if you do not wish to have this please inform the Doctor or Nurse at your consultation

### Personal Medical History (Please tick if you have had/have any of the following and give more details where possible)

Heart Attack	Heart Disease	Heart Failure	Angina (Heart condition)
Stroke/TIAs	Hypertension (on medication)	Hypothyroidism (Underactive)	Depression (on medication)
Learning Disabilities	Diabetes Type 1	Diabetes Type 2	Epilepsy
COPD	Asthma Requiring Inhalers	Chronic Kidney Disease	Schizophrenia
Bipolar Disorder	Other Psychoses	Cancer	Dementia

**44. Please give details of current or past medical problems other than previously specified:**

**45. Please give details of any hospital treatment or operations?**

**46. Please state any relevant medical Family History: Mother:** \_\_\_\_\_ **Father:** \_\_\_\_\_  
**Brother:** \_\_\_\_\_ **Sister:** \_\_\_\_\_ **Other (State relationship):** \_\_\_\_\_

**47. Please give details of any medication you take on a regular basis:**

**48. Allergies: Please give details of any allergies you have:**

### Summary Care Record (SCR) For more information go to [www.nhs.uk/summary](http://www.nhs.uk/summary) or take a leaflet from reception

**49. Would you like a Summary Care Record? Yes**  **No**  Please see information provided.

### Care.data For more information go to [www.nhs.uk/nhsengland/thenhs/records/healthrecords/pages/care-data.aspx](http://www.nhs.uk/nhsengland/thenhs/records/healthrecords/pages/care-data.aspx) or take a leaflet from reception.

**50. Are you happy for your anonymised data to be shared for secondary use? Yes**  **No**

**51. Are you happy for your anonymized data to be shared with 3<sup>rd</sup> parties by HSCIC? Yes**  **No**

**CIDR** Camden Integrated Digital Record, is a local initiative to enable your care providers in Camden to view the relevant information when treating you and so give you the best possible care.

**52. You are automatically Opted In to CIDR if you would like to Opt Out please ask Reception for the CIDR Opt out form.**

**53. Your Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_