HUDDERSFIELD ROAD PARTNERSHIP

PRE-REGISTRATION & HEALTH QUESTIONNAIRE

Please answer the questions below as accurately as you can, as it may take up to 3 months for us to obtain your medical records from your previous GP and we need to know a little bit about you. This will help us treat any problems you may have and help us give you any appropriate health advice.
Thank you

Name ……

Date of Birth ……

Mobile Number ……

Email ……

How many units of alcohol do you drink weekly? ……


Pint of regular beer/lager/cider
2 UNITS


Glass of wine 175 ml
2 UNITS


Bottle of wine
9 UNITS


Single measure of spirits
1 UNIT


Alcopop/Bottle of lager
1.5 UNITS

How often do you have a drink that contains alcohol?
☐ Never ☐ Monthly ☐ Once a week ☐ 3-4 times per week ☐ 5+ times per week

How many units of alcohol do you have on a typical day when drinking?
☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ 9+

How often do you have 6 or more units of alcohol in one session?
☐ Never ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily or almost daily

How many sessions of vigorous activity have you done in the last 4 weeks?
(one session is 30 mins of vigorous activity)
☐ none ☐ one session ☐ two sessions ☐ three sessions ☐ four sessions ☐ more than four

Do you smoke?
☐ Yes ☐ No ☐ Previously

If you have previously smoked, when did you stop? ……

If you answered yes,
How many do you smoke daily?
☐ less than 5 ☐ 5-10 ☐ 10-20 ☐ 20-30 ☐ more than 30

Are you ready to quit?
☐ YES ☐ NO

Please turn over to complete your health questionnaire …

Do you have any special dietary requirements?
☐ **Yes** ☐ **No**

Please specify……
☐ **Vegetarian** ☐**Vegan** ☐ **Low fat** ☐**Gluten Free** ☐ **Dairy Free**

Do you suffer from any of the following?

Diabetes ☐ YES ☐ NO
Asthma ☐ YES ☐ NO
Epilpesy ☐ YES ☐ NO
Heart Disease ☐ YES ☐ NO
High Blood Pressure ☐ YES ☐ NO
Osteoporosis ☐ YES ☐ NO
Other (please specify) ……

Have you ever had any of the following?

Stroke ☐ YES ☐ NO
Heart Attack ☐ YES ☐ NO

Has anyone in your family (mother, father, siblings or grandparents) suffered from any of the above? If you have answered yes, please provide details below.

Which family member ……..

Which disease ……

At what age ……

Please provide details of any serious illnesses or operations you have had in the last year

……

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Please list any medication that you are currently taking (including oral contraceptive)

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……

Do you have any allergies? e.g Penicillin/Aspirin/Nuts

☐ **Yes** ☐ **No**

Details

……

……

……

Signed ……

Date ……