

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
<p>Please fill in this information at home or go to the Health Information Room as soon as you arrive at the surgery:</p> <p>What is your height? _____</p> <p>What is your weight? _____</p> <p>What is your waist circumference? _____</p> <p>Blood pressure _____</p> <p>Pulse rate _____</p> <p>If you monitor your blood pressure at home, please bring 10 readings done over the course of 5 days as these tend to be more accurate than surgery readings.</p>		
<p>Is your general health:</p> <p> <input type="checkbox"/> about the same <input type="checkbox"/> getting better <input type="checkbox"/> getting worse </p>		
<p>Do you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If YES – how many cigarettes do you smoke per day? _____</p> <p>If you do not smoke now, have you ever smoked? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If so, how many did you smoke and when did you stop? _____</p> <p>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 quittyready.co.uk</p>		
<p>Do you ever have a drink that contains alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If YES – please complete the alcohol questionnaire on page 2.</p>		
<p>Do you take 'over the counter' Aspirin every day? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		
<p>Over the last two months have you felt depressed or low in mood?</p> <p><input type="checkbox"/> Yes. If yes, please give details</p> <p><input type="checkbox"/> No.</p>		
<p>Do you or your family have any concerns about your memory?</p> <p><input type="checkbox"/> Yes. If yes, please book an appointment with a doctor.</p> <p><input type="checkbox"/> No.</p>		
<p>Describe your level of breathlessness related to the activities below (please tick only one)</p> <p><input type="checkbox"/> Not troubled by breathlessness</p> <p><input type="checkbox"/> Not troubled by breathlessness except on strenuous exercise</p> <p><input type="checkbox"/> Short of breath when hurrying or walking up a slight hill</p> <p><input type="checkbox"/> Walks slower than contemporaries on level ground because of breathlessness, or has to stop for breath when walking at own pace</p> <p><input type="checkbox"/> Stops for breath after walking about 100m or after a few minutes on level ground</p> <p><input type="checkbox"/> Too breathless to leave the house, or breathless when dressing or undressing</p>		

Alcohol Questionnaire

If you drink alcohol please answer the following questions.

This questionnaire 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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