**Kingsway Surgery Medication Review Form**

**Patient Details**

Name: Address:

Telephone number:

Mobile Number:

Date of Birth:

NHS Number:

# Measurements

1. Height (m)
2. Weight (Kg)
3. Waist Circumference (cm)
4. Systolic Blood Pressure (mmHg) (3 readings)
5. Diastolic Blood Pressure (mmHg) (3 readings)
6. Peak Flow (l/min)

\*Please note the Peak flow is for Asthmatics only

# Smoking

1\*. Smoking Habit

* Smoker
* Never Smoked Tobacco
* Stopped Smoking
* User of Electronic Cigarettes
* Ex User of Electronic Cigarettes

1a. If you smoke – how many per day?

1. Would you like advice on stop smoking?
* N/A
* Yes
* No

# Alcohol

1. How often do you have a drink containing alcohol? N/A
* N/A
* Never
* Monthly or Less
* 2-4 times per month
* 2-3 times per week
* 4+ times per week
1. How many units of alcohol do you drink on a typical day when you are drinking? N/A
* N/A
* 1-2
* 3-4
* 5-6
* 7-9
* 10+
1. 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?
* N/A
* Never
* Less than monthly
* monthly
* weekly
* Daily or Almost daily
1. How often during the last year have you found that you were not able to stop drinking once you had started?
* N/A
* Never
* Less than monthly
* monthly
* weekly
* Daily or Almost daily
1. How often during the last year have you failed to do what was normally expected from you because of your drinking?
* N/A
* Never
* Less than monthly
* monthly
* weekly
* Daily or Almost daily
1. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?
* N/A
* Never
* Less than monthly
* monthly
* weekly
* Daily or Almost daily
1. How often during the last year have you had a feeling of guilt or remorse after drinking?
* N/A
* Never
* Less than monthly
* monthly
* weekly
* Daily or Almost daily
1. How often in the last year have you been unable to remember what happened the night before because you had been drinking?
* N/A
* Never
* Less than monthly
* monthly
* weekly
* Daily or Almost daily
1. Have you or someone else been injured as a result of your drinking?
* N/A
* No
* Yes, but not during last year
* Yes, during the last year
1. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?
* N/A
* No
* Yes, but not during the last year
* Yes, during the last year

# Medication List

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication/ Drug (this includes all items on your prescription and any over the counter medication) | Do you know what the Medication/Drug is for?(YES/NO) + state a reason | Do you feel it is effective? | Any Issues e.g side effects, problems with device etc? |
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**Additional Information/ Comments**

**Would you like any extra support with Healthy Lifestyle?**

* No
* Yes

**Declaration**

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I undertake to inform you any changes therein, immediately. I certify that all the above information is correct to the best of my knowledge.

**Signature: Date:**