

## Update your details

Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Tel number: \_\_\_\_\_ mobile: \_\_\_\_\_

What is your smoking status? (please circle one only)

Never / ex / current

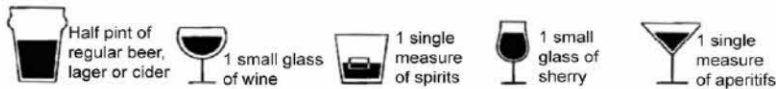
How long have you been /did you smoke for? \_\_\_\_\_

How many do you (or did you) smoke a day? \_\_\_\_\_

When did you stop smoking? \_\_\_\_\_

How many units of alcohol do you consume in 1 week? \_\_\_\_\_

This is one unit of alcohol...



How often do you have 6 or more units (female) of alcohol on a single occasion or 8 or more units (male) on a single occasion over the last year? (circle as appropriate)

(0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily

How often during the last year have you failed to do what was normally expected of you because of drinking? (circle as appropriate)

(0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking? (circle as appropriate)

(0) Never      (1) Less than monthly      (2) Monthly      (3) Weekly      (4) Daily

Has a relative or friend , Doctor or health worker been concerned about your drinking or suggested that you cut down? (circle as appropriate)

(0) No      (2) Yes but not in the last year      (4) Yes during the last year

TOTAL \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Please hand the completed form to a member of the reception staff.

Thank you for your time