

# Questionnaire






## Dear Patient

As part of my service I am examining lifestyle issues likely to affect the health of my patients. This will assist me in giving the best treatment possible. To help me do this, could you please complete this questionnaire in the waiting room before your appointment. When you have finished, please hand it back to the receptionist. I will explain the results to you during your consultation. Your answers to these questions will be treated in strict confidence.

Name \_\_\_\_\_




Age \_\_\_\_\_ Sex: Male  Female

**1 standard drink =**

 OR  OR 

middy of beer (285mls)      small glass of wine (100 mls)      nip of spirits (30 mls)

**1.5 standard drinks =**

 OR  OR 

1 schooner (425mls)      1 can (375 mls)      1 stubby (375 mls)

- How often do you have a drink containing alcohol?  
Never       Monthly or less       2-4 times a month       2 to 3 times a week       4 times a week or more
- How many standard drinks do you have on a day when you are drinking?  
1 or 2       3 or 4       5 or 6       7 or 8       10 or more
- How often do you have 6 or more standard drinks on one occasion?  
Never       Less than monthly       Monthly       Weekly       Daily or almost daily
- 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
- How often during the last year have you failed to do what was normally expected of you because of your drinking?  
Never       Less than monthly       Monthly       Weekly       Daily or almost daily
- How often during the last year have you needed a drink in the morning to get you going after a heavy drinking session?  
Never       Less than monthly       Monthly       Weekly       Daily or almost daily
- How often during 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 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
- 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 friend, relative, doctor or other health worker been concerned about your drinking or suggested you cut down?  
No       Yes, but not in the last year       Yes, during the last year

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