

Patient Health Questionnaire

January 2020

This is a private form and all information will be treated confidentially.

Contact details

Title:	Forename:	Surname:
Address:		
Date of Birth: / /	NHS No (if known):	Home telephone No:
Email:	Mobile No:	Consent to leave voice messages on home / mobile tel? Home: Y / N Mobile: Y / N
By giving us your mobile telephone number/email address you are consenting for us to be able to contact you via SMS/email. <u>Important: It is your responsibility to advise the Surgery of any changes to your contact details.</u>		
Please state your preferred method of contact: Home Telephone / Mobile / Email / Letter		
Marital Status: Single / Married / Cohabiting / Civil Partnership / Separated / Divorced / Widowed / Other		
Next of kin Name:	Relationship:	
Contact details (tel):		
At same address? Y/N Address if different:		

Ethnic Origin (please circle one)	
[Asian ethnic group] [Bangladeshi] [Black African] [Black Caribbean] [Black other mixed origin] [Black other non-mixed origin] [Chinese] [Indian] [Other] [Other black ethnic] [other ethnic mixed origin] [Other ethnic non-mixed] [Pakistani] [White British] [White, other]	
Other.....	I do not wish to answer.

Language

Is English your first language?	Yes	No
If English is not your first language what is?		
Will you need an interpreter to help you with medical appointments?	Yes	No

Occupation

Main Occupation:

Allergies

Are you allergic to anything?

Also available in large print – Please ask reception

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Family history

Please tick as appropriate and state age when the condition started.

	Father	Age	Mother	Age	Brother	Age	Sister	Age
Diabetes								
High Blood pressure								
Heart attack								
Stroke								
Asthma								
Cancer								

Current Medical Status

Height..... Weight..... BPSys.....Dia

If you do not have a recent BP reading, please use the automated machine in the waiting room.

Alcohol

Questions	0	1	2	3	4	Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times a month	2 -3 times a week	4+ times a week	
How many standard alcohol drinks do you have on a typical day when drinking?	1 - 2	3 – 4	5 – 6	7 - 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	



Activity

How often do you take moderate to vigorous exercise for at least 20 minutes?

Exercise physically impossible	No regular exercise	Once per week	Twice per week	Three or more times per week
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Moderate to vigorous exercise is activity that makes you sweat or raise your pulse such as swimming, cycling, brisk walking.

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Smoking Status

Which of the following best describes you?

Never Smoked	Ex-Smoker. Date Stopped.....	Current Smoker. Amount per day.....
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If you would like help to stop smoking please ask for information on NHS support to quit. Contact the national NHS stop smoking helpline on 0300 123 1044 or contact Lloyds Smoking Cessation Support Group.

Medication

Do you take any regular medication?	Yes	No
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If **yes**, please attach a repeat prescription list. When you need more of your repeat medication, you do not need to see your Doctor, please contact your Doctors secretary.

Repeat prescriptions: Can be requested by using the repeat slip Mon - Fri 8.30am - 6.00pm at the surgery.

Patient Online Access which you can register for from Reception or going onto our website.

Via e-Consults through our website.

Please allow at least 48 hours before collecting medications from dispensary or chemists.

Carer

Do you look after someone who is ill, frail, disabled or mentally ill?	Yes	No
Does someone look after you?	Yes	No

If the answer to either question above is yes please ask about Carer support services.

Other Support

Do you use anything to help with your mobility, hearing or speaking?	Yes	No
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If yes, please tick any of the list below which you use:

Wheelchair	Walking aid	Hearing aid	An advocate	Hearing loop	Text phone
Other (please state)					

Do you require communications in an alternative format?	Yes	No
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If yes, please tick any of the list below which you require.

Audio tape	Brail	Large print
Other (please state)		

Although we will do our best to supply information in the requested format this may not always be possible.

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Sharing your medical record

Summary Care Record contains details of a small but important part of your GP medical records - medications, allergies and adverse reactions. They are accessible to authorised health care staff in A&E Departments throughout England. You should always be asked your permission before anybody looks at your Summary Care Record. More information is available at:

<http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/servicedescription.aspx>

You can choose to have other useful information added to your SCR, including:

- Your illnesses and any health problems
- Operations and vaccinations you have had in the past
- How you would like to be treated – such as where you would prefer to receive care
- What support you might need
- Who should be contacted for more information about you

Please read the accompanying information leaflet and tick the box below if you wish your information to be shared with your consent with healthcare professionals treating you in other settings.

Do you want to have a Summary Care Record with additional information?	
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Signed Today`s Date.....

Please return this form together with your completed GMS1 REGISTRATION FORM, PHOTO ID and PROOF OF ADDRESS / UTILITY BILL.

Children under 5 years old will need to provide a copy of BIRTH CERTIFICATE and RED BOOK when registering.

For office use only	
Proof of residency / ID checked	
<input type="checkbox"/> Passport	<input type="checkbox"/> Birth Certificates
<input type="checkbox"/> Driving Licence	<input type="checkbox"/> Proof of Address / Utility Bill
<input type="checkbox"/> New Patient appointment booked	<input type="checkbox"/> Work / Study Permit
<input type="checkbox"/> Alcohol Consumption checked – Task to GP if high	
<input type="checkbox"/> Carers answer checked – Cares information sent to patient	
<input type="checkbox"/> Current Smoker? – Smoking cessation advice offered.	
<input type="checkbox"/> Date:	Signature of member of staff:

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