Patient Health Questionnaire For Adults

Orchard Medical Practice
Innisdoon, 1 Crow Hill Drive, Mansfield
Nottinghamshire, NG19 7AE

Tel: 01623 400 100

Patient's Details

Title:	☐Mr ☐ Mrs ☐Miss ☐ Ms	**Surname:**	
Date of Birth:	….…/….…./……. dd/mm/yyyy	**First Names:**	
Occupation:		**Previous Surnames:**	

Home Address:	**Home Tel.:**	
	Work Tel.:	
	Mobile:	
Postcode:	**E-Mail:**	

First Language / Mother tongue:	
Name and Address of Previous GP:	

Ethnic Group

White	☐ British
	☐ Irish
	☐ Other (please specify)

Black	☐ Caribbean
	☐ African
	☐ Other (please specify)

Asian	☐ Indian
	☐ Pakistani
	☐ Chinese
	☐ Other (please specify)

Mixed	☐ White + Black Caribbean
	☐ White + Black African
	☐ White + Asian
	☐ Other (please specify)

Proof of Identity and Address Provider?

☐ Birth Certificate	☐ Driving Licence	☐ Passport	☐ Utility Bill
☐ Allowance Book	☐ Solicitor's Letter	☐ Offer of Tenancy	☐ Other (please state)

Medical Information

Please list any serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place.

Have you ever suffered from? (tick as appropriate):

Epilepsy	☐Yes ☐No		Blindness/Glaucoma	☐Yes ☐No
High Blood Pressure	☐Yes ☐No		Diabetes	☐Yes ☐No
Heart Attack/Stroke	☐Yes ☐No		Depression	☐Yes ☐No
Cancer	☐Yes ☐No		Asthma	☐Yes ☐No
Eczema/Hay Fever	☐Yes ☐No		COPD	☐Yes ☐No

Are you registered disabled? (If YES please give details)	☐ **Yes** ☐ **No**

Please list any medicines being taken and the amount:

Are you allergic to any medicines and if so which?	☐ **Yes** ☐ **No**
Have you ever refused treatment/screening of any kind and if so, what?	☐ **Yes** ☐ **No**

Other Information

Do you have a carer? (if YES please give details)	☐ **Yes** ☐ **No**
Are you a carer? (if YES please give details)	☐ **Yes** ☐ **No**
Do you hold a Living Will? (A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of serious illness).	☐ **Yes** ☐ **No**
Women: Have you ever had a cervical smear? (If yes, when and where?)	☐ **Yes** ☐ **No**

Are you currently pregnant? If yes, how many weeks If yes are you taking any regular medication Do you require an appointment with the GP	☐ **Yes** ☐ **No** [ ] Wks ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
Do you smoke? If 'NO', have you ever smoked? If 'YES' how many cigarettes or ounces of tobacco per week? Would you like advice on giving up smoking?	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** [ ] ☐ **Yes** ☐ **No**

Alcohol Consumption					
Questions					
	0	**1**	**2**	**3**	**4**
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 -3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	2 – 4 times per month	2 -3 times per week	4+ times per week
How often during the last year have you needed an alcoholic drink in the morning to get yourself 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 remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or somebody else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year
What is your Height?			What is your Weight?		

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure diabetes or any inherited disease.

For Patients aged 65 and over

Please give name, address and telephone number of next of kin

For Patients aged 65 and over or those with a chronic disease (e.g. asthma or diabetes).

Have you had a flu vaccination? Enter Date or 'Never'	
Have you had a pneumococcal vaccination? Enter Date or 'Never	

Signature **(you will be asked to sign this form when you visit the practice).**	**Date:** **……/……/……….** dd/mm/yyyy