Patient Health Questionnaire

PLEASE COMPLETE CLEARLY IN BLOCK LETTERS.
All new patients are requested to complete a health questionnaire.
It helps us to understand you better prior to your full medical records arriving from your previous doctor.
All information given on this form is kept strictly confidential and revealed to no-one without your permission

Have you been registered with us before? ☐ **Yes** ☐ **No**

Burton & Bransgore Medical Centres

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About Yourself

Surname (Family name)		**ALL Other Names**	
Title		**Date of Birth**	
Current Address	**Postcode**		
Home Tel No.		**Mobile Tel No**	
Next of Kin (name and relationship)			
Address of Next of Kin	**Postcode**		
Next of Kin Tel No		**Next of Kin Mobile No**	
Occupation	If retired, previous occupation		

Your current Health (not applicable for children under the age of 15 years)

Height		**Weight**	

Do you Drink Alcohol? ☐ **Yes** ☐ **No** — **If YES, how many units per week?**

Complete below if you consume more than 4 units a week where 1 unit = half a pint of bitter, a small glass of wine or a single measure of spirits.

How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ **1 or 2** ☐ **3 or 4** ☐ **5 or 6** ☐ **7 or 8 or 9** ☐ **10 or more**

How often do you have 6 or more drinks on one occasion?
☐ **Never** ☐ **Less then Monthly** ☐ **Monthly** ☐ **Weekly** ☐ **Daily or almost daily**

Have you ever Smoked? ☐ **Yes** ☐ **No** — **If Yes, Please ask Reception for cessation advice form and**

Do you currently Smoke? ☐ **Yes** ☐ **No** — **Please state how many per day?**

Do you have concerns about you memory? ☐ **Yes** ☐ **No** — **If YES, would you like to discuss these concerns with a clinician?** ☐ **Yes** ☐ **No**

ADULT FEMALES ONLY:

Have you ever had a cervical smear? ☐ **Yes** ☐ **No** — **Was the result normal?** ☐ **Yes** ☐ **No**

When was it last performed? Month / Year — **Was it done in the UK?** ☐ **Yes** ☐ **No**

If so, please indicate ☐ **Clinic/GP** ☐ **Private**

Immunisations

Adults (if known)	**Date**	**Given by Previous GP**	**Where done GP/Clinic/Country if other than UK**
Booster DIP/Tet/Polio			
Tetanus (only) Vaccination			
Other (e.g. Travel Vaccinations)			
Over 65/Patient at risk Influenza (flu)			
Over 65/Patient at risk Pneumonia			
Child (if known)	**Dates and where if done outside the UK**		

Past Medical History

Do you or have you ever had any of the following conditions? (Tick all that apply and give details)

- ☐ **Diabetes**
- ☐ **Epilepsy**
- ☐ **Asthma**
- ☐ **Blood Pressure Problems/Hypertension**
- ☐ **Heart condition** (Including Heart Disease/Stroke, etc.)
- ☐ **Eating disorder** (including Anorexia/Bulimia)
- ☐ **Skin Problems**
- ☐ **Back, Joint, Muscle Problems**
- ☐ **Mental, Nervous, Emotional Problems**
- ☐ **Any Disability we should be aware of**
- ☐ **Osteoporosis**
- ☐ **Any Other conditions**
- ☐ **Operations** (e.g., Appendicectomy, Hernia, Splenectomy, vasectomy, etc.)

Please give details of any recent investigations you may have had carried out:	**Where Performed**	**Details**
☐ **Eye Test**		
☐ **ECG**		
Female – ☐ **Gynae investigations** (e.g., colposcopy/Ultrasound, etc.)		
Male – ☐ **Prostate investigations, etc.**		

Any current medication/treatment (including contraceptive pill)?

Any allergies to drugs or other materials?

Family history: Has a very close relative suffered from heart disease or had a stroke under the age of 55? ☐ **Yes** ☐ **No**
If 'Yes' what relation: _____

Please provide any further relevant family history (this may include details of Stroke/Heart attack/Heart Disease/ Cancer/ Hypertension)

Are you a carer? ☐ **Yes** ☐ **No** — If Yes, please give name and address of the person you care for:

Do you have a carer? ☐ **Yes** ☐ **No** — If Yes, please give name and contact details of your carer:

Ethnic Category

With effect from 1st October 2008, the UK government require all Doctors to record the Ethnicity & First Language for all patients. Please tick relevant box below:

☐ **White** ☐ **Black** ☐ **Asian** ☐ **Mixed** ☐ **Chinese** ☐ **Other** ☐ **Patient Declined**

First Language:

Signature: **Date:**

Thank you for your co-operation

Some of your medical information may be held nationally. Please tick this box if you do not wish your records to be accessed by other healthcare officials. ☐ **Refused Consent for upload of records to National Database.**

Once completed, please hand this form to Reception staff.