

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

Bransgore Medical Centre
Ringwood Road
Bransgore
Christchurch
Dorset BH23 8AD
Tel. 01425 672857

Burton Medical Centre
123 Salisbury Road
Burton
Christchurch
Dorset BH23 7JN
Tel. 01202 474311

Have you been registered with us before? Yes No

<http://www.theburtonsurgery.co.uk>

About Yourself

Surname (Family name)	<input type="text"/>	ALL Other Names	<input type="text"/>
Title	<input type="text"/>	Date of Birth	<input type="text"/>
Current Address	<input type="text"/>		
		Postcode	<input type="text"/>
Home Tel No.	<input type="text"/>	Mobile Tel No	<input type="text"/>
Name of Previous Doctor	<input type="text"/>	Your last address you had when with the Doctor	<input type="text"/>
Next of Kin (name and relationship)	<input type="text"/>		
Address of Next of Kin	<input type="text"/>		
		Postcode	<input type="text"/>
Next of Kin Tel No	<input type="text"/>	Next of Kin Mobile No	<input type="text"/>
Occupation	<input type="text"/>		
	If retired, previous occupation		

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

Height	<input type="text"/>	Weight	<input type="text"/>
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Do you Drink Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, how many units per week?	<input type="text"/>
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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 than Monthly Monthly Weekly Daily or almost daily

Have you ever Smoked? Yes No

If Yes, how many per day?

Do you currently Smoke? Yes No

Adult Females

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.)

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Please give details of any recent investigations you may have had carried out:	Where Performed	Details
<input type="checkbox"/> Eye Test		
<input type="checkbox"/> ECG		
Female – <input type="checkbox"/> Gynae investigations (e.g., colposcopy/Ultrasound, etc.)		
Male – <input type="checkbox"/> 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 (93c3)

Once completed, please hand this form to Reception staff.

PATIENT HEALTH QUESTIONNAIRE (Continued)

ALCOHOL – If you consume more than 4 units per week, please complete the following two questions:



How many drinks containing alcohol do you have on a typical day when you are drinking?

Please tick one box

- 1 or 2 Drinks
- 3 or 4 Drinks
- 5 or 6 Drinks
- 7 or 8 or 9 Drinks
- 10 or more Drinks

How often do you have six or more drinks on one occasion?

Please tick one box

- Never
- Less than Monthly
- Monthly
- Weekly
- Daily or almost Daily

Thank you for your cooperation