Patient Health Questionnaire for Adults

Orchard Medical Practice
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Mansfield
NG18 5GG
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www.orchard-medical.co.uk

Patient Details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐	Surname: Previous Surname/s:	First Names:	Date of Birth:
Home Address: Postcode:		Home Tel: Work Tel: Mobile: Email:	First Language:
Name & 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
	☐ Pakistani
	☐ Chinese
	☐ 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/Hayfever	☐ Yes	☐ No	COPD	☐ Yes	☐ No

Are you registered disabled? (if yes please give details) ☐ Yes ☐ No	Details:

Please list any medicines being taken and the amount:

Are you allergic to any medicines and if so which? ☐ Yes ☐ No	Details:

Have you ever refused treatment/screening of any kind? if so, please give details. ☐ Yes ☐ No	Details:

Other Information

Do you have a carer? (if YES please give details) ☐ Yes ☐ No	Details:
Are you a carer? If YES please give details of the person you care for) ☐ Yes ☐ No	Details:
Do you hold a Living Will? (A Living Will is documentation regarding your personal wishes in respect of medical intervention at the time of the serious illness) ☐ Yes ☐ No	Details:

Women: Have you ever had a cervical smear? (If yes, when and where?) ☐ Yes ☐ No	Details:

Are you currently pregnant? ☐ Yes ☐ No If yes how many weeks? _____ Are you taking any regular medication? ☐ Yes ☐ No Do you require any appointment with the GP ☐ Yes ☐ No	Details of any medication:

Smoking

Do You smoke?	Yes ☐	No ☐
If 'no' have you ever smoked?	Yes ☐	No ☐
If 'yes' how many cigarettes/cigars or ounces of tobacco per week? _____		
Would you like advice on giving up smoking?	Yes ☐	No ☐

Alcohol Consumption

1 drink = 1 pint of beer or 1 glass of wine or 1 single spirits					
	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Men How often do you have EIGHT or more drinks on one occasion? **Women** How often do you have SIX or more drinks	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
How often during the last year have you NOT been able to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐
How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐
In the last year has a relative or friend or a doctor or a health worker been concerned about your drinking or suggested to cut down?	No ☐	Yes, on one occasion ☐	Yes, on more than one occasion ☐		

Height and Weight

What is your Height?	What is your Weight?
_____	_____

Family History

Please state in your family is there any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease

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 ever had a flu vaccination? Enter date or 'Never'	
Have you had a pneumococcal vaccination: Enter date or 'Never'	

Summary Care Record

NHS healthcare staff caring for you may not be aware of your current medication, allergies, you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

If you would like to have a summary care record in place that can be accessed by healthcare staff please tick the box.

I wish to have a summary care record ☐

I do not wish to have a summary care record ☐

Feedback Information

How did you hear about Orchard Medical Practice:

Orchard Website: ☐ Facebook: ☐ Word of Mouth: ☐

NHS Choices Website: ☐ Recommended by someone: ☐

Other (please state): _____

I believe all the information in my new patient health questionnaire to be accurate and correct to the best of my knowledge (please sign and date below when you visit the practice)

Signature: _____ Date: _____

Orchard
Medical Practice

Consent Form

I, _____, have today been given the opportunity to discuss sharing of my patient record and have read and understood the leaflet "Your electronic patient record & the sharing of information"

I understand that the same record is used to store information recorded by different members of the care teams who are currently involved in providing my care, including but not limited to doctors surgeries, district nurses, health visitors, physiotherapists, podiatrists, social care and child health. I understand that I will be asked to give consent by each care team before they are able to access or add to any shared data about me.

Share-out * Circle your choice

I would* / would-not* like the information recorded at **Orchard Medical Practice** to be available to be seen by other care teams who are involved in my care where I have granted those care teams access to see my shared data.

Share-in * Circle your choice

I would* / would-not* like the information recorded at other care teams who are involved in my care to be seen by members of the team at **Orchard Medical Practice** where I have granted those care teams the right to add to my shared data.

I understand that I can change my decision at any time.

Signed

Patient …….. Date Todays date

OR

Patient representative ……

Relationship to patient ……