Patient Health Questionnaire

June 2023

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

Contact details

Title:	Forename:	Surname:
Address:		
Key Code for Emergency Access (if applicable) :		
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. ***Important: It is your responsibility to advise the Surgery of any changes to your contact details.***		
Please state your preferred method of contact: Home Telephone / Mobile / Email / Letter / Please provide an address we can use for correspondence if you are currently homeless if it is needed		
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:	
Permission to discuss medical records : Y/N	
Can this person be used as your emergency contact : Y/N	
Do you give consent for this person to discuss your medical records : Y/N **** Note : By ticking YES this gives FULL entitlement to discuss your medical records in detail including medication, appointments, test results and other information. Please only tick YES if you are entirely happy for this information to be disclosed.**	

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

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Occupation

Main Occupation:

Allergies

Are you allergic to anything?

Have you ever serviced in the Armed Forces?	Yes	No

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……………………………… BP …….…..Sys……….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 units 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 units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

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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

Moderate to vigorous exercise is activity that makes you sweat or raise your pulse such as swimming, cycling, brisk walking.

Smoking Status

Which of the following best describes you?		
Never Smoked	Ex-Smoker. Date Stopped……………………	Current Smoker. Amount per day……………………………..

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

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 order your repeat prescription by:

By using the repeat slip Mon - Fri 8.00am - 6.00pm at the surgery or sending in via the post.
On the NHS App which you can register for online by downloading the app from the App store.
By emailing your request to: cheritonprescriptions@nhs.net
***** Please allow at least 3 working days before collecting medications from dispensary. *****

Carer

Do you look after someone who is ill, frail, disabled or mentally ill?	Yes	No
Are you a Child who looks after someone who is ill, frail, disabled or mentally ill?	Yes	No
Details of person you are Carer for: Name: Date of Birth: Address (if different from your address): Telephone number (if different from your number): Relationship to you: Are you their main carer: GP Details (if different to your own): Emergency Contact:		
Does someone look after you?	Yes	No
Please pass my details to Devon Carers and ask them to contact me to arrange a Carers Health & Wellbeing Check. This check will help you to identify any areas where, as a care you may require support & enable you to access appropriate services.	Yes	No

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Other Support

Do you use anything to help with your mobility, hearing or speaking?	Yes	No

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

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.

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?	

Signed ……………………………………………………………. Today`s Date…………………………………….….

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

New babies being registered will need to show a copy of BIRTH CERTIFICATE.

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