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.

http://www.guildowns.nhs.uk
http://portal.surrey.ac.uk/scs/health/hc

The Oaks Surgery
Applegarth Avenue
Guildford GU2 8LZ

Wodeland Avenue Surgery
91/93 Wodeland Avenue
Guildford GU2 4YP

Stoughton Road Surgery
2 Stoughton Road
Guildford GU1 1LL

Guildowns University Medical Centre
University of Surrey
Guildford GU2 7XH

Tel: 01483 409309

About Yourself

Surname (family name) | First names

Title | Gender | Marital status (eg Single, Married, Separated, Widowed) | Date of birth (Day) (Month) (Year)

Any previous surname (Family name) | Main language

Town and Country of birth (If London, area required) | If from abroad - visa expiry Date/duration of stay

Guildford accommodation
House name or no. | Road
Town | Postcode
Is this address a residential care home ? Yes | No

Home telephone number | Mobile tel. no.

Email address

Emergency contact (Name and relationship)
UK tel no: if possible

Are you or do you have a carer | I am a carer | I have a carer | Details

Do you or (your carer) have any information or communication needs Yes | No

If yes , how could we meet these needs ?

Please tick if you would be happy for us to share those needs with other NHS organisations who need to get in touch with you (eg if you transfer to a different surgery or a hospital needs to contact you)

Name and address of previous UK doctor | Your address when registered with this doctor

If born outside UK

Date first entered UK | Have you had a doctor since entering the UK ? Yes | No

Dates of previously leaving UK and returning (if applicable) | Any other permanent address you have had in the UK

Surrey University Students ONLY

Name of university department | Student ID no. | University Email address

Course start date | End date

Have you had a MMR booster ? Yes | No | Approx date | Have you had the Men ACWY vaccine? Yes | No | Approx date

If you are returning from the Armed Forces

Your address before enlisting

Service or personnel No.

Enlistment date

Leaving date

Please ATTACH your signed Medical Form FP53 to release your medical records

Your Current Health (Patients over 15 years ONLY)

Height cm/m

Weight kgs

Have you ever smoked? Yes ☐ No ☐

Do you currently smoke? Yes ☐ No ☐

How many per day?

If you smoke, we advise you to contact the practice for information on how to stop.

Do you drink alcohol? Yes ☐ No ☐

How much alcohol per week?

Please answer in 'Units', where 1 unit = half a pint of beer, a glass of wine or a single measure of spirits.

If you drink alcohol please tick the relevant boxes.

1. How often do you have a drink containing alcohol?

Never ☐ Monthly or less ☐ 2-4 times a month ☐
2-3 times a week ☐ 4+ times a week ☐

2. How many standard drinks containing alcohol do you have on a typical day?

1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 8 ☐ 10 or more ☐

3. How often do you have 6 or more drinks on one occasion?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

Adult females

Have you ever had a cervical smear? Yes ☐ No ☐

A first smear is needed one year after first sexual contact, but not before 25 years of age.

Was the result normal ? Yes ☐ No ☐

When was it done ? Month Year

Was it done in the UK ? Yes ☐ No ☐

If so, was it done at a clinic or by your GP? Clinic ☐ GP ☐

Date of vaccinations

VACCINATIONS:

Influenza (flu) in the last 12 mths.

Pneumococcal (pneumonia)

CHILDREN ONLY (6 YEARS OR UNDER) please list (or attach information for) ALL vaccinations

Vaccinations	Date of vaccination	Vaccinations	Date of vaccination

Do you have any medical conditions we should be aware of ? eg diabetes, epilepsy, asthma etc.

Any current medication/treatment (including contraceptive pill)?

Any allergies to drugs or other materials ?

Family history - Please report any significant medical condition affecting your family eg: stroke, heart disease, diabetes

Ethnic Category

White	British	☐	Asian/AsianBritish	Pakistani	☐
	Irish	☐		Bangladeshi	☐
	Other White	☐		Other Asian	☐
Mixed	White & Black Caribbean	☐	Black/Black British	Black Caribbean	☐
	White & Black African	☐		Black African	☐
	White & Asian	☐		Other Black	☐
	Other Mixed	☐	Other Ethnic	Chinese	☐
Asian/AsianBritish	Indian	☐		Other Ethnic Category	☐
				Not Stated	☐

Thank you for your co-operation

Signature

Date

Summary Care Record

Information about medicines you are taking, any allergies you suffer from and any adverse reactions to medicines will be available to other healthcare staff so they can provide safer care.

Please tick here if you do not wish this information to be available ☐

Once completed

Please take this form along with proof of identification (passport or UK driving license) and utility bill/student ID card to the Guildowns surgery of your choice.

For official use ONLY

ACCEPTED

- Passport ☐
- Visa date ☐
- BRP ☐

OR

- UK photo driving licence (if born in the UK) ☐
- UK birth certificate ☐
- Utility bills e.g (Water,gas,telephone(not mobile) ☐

Plus

- Student ID Card ☐
- Bank statement ☐
- Tenancy agreement including expiry date ☐

Checked by

Date