Patient Health Questionnaire

Personal Details: **Title (Mr/Mrs/Miss/MS).....**

Name		Date of birth	
Mobile number		Email	
Address			
Postcode		Work No	

Details of person to be contacted in an emergency			
Name		Telephone number	

Occupation			
Language of Preference		If Student, which department	

Your Lifestyle

What is your weight?			What is your height?	
Do you smoke?	NO			
(please tick)	YES		If yes how many per day?	
We offer advice on smoking and a smoking cessation clinic in the surgery.				
Please indicate if you would like information on this		YES	NO	

Your Health

Do you have any health problems? (please tick)		YES	NO	
If yes, what are your problems?				

Are you currently taking any medication? (please tick)		YES	NO	
If yes, please give details				

Do you have any allergies (please tick)		YES	NO	
If yes, please give details				

Have you been immunised against the following? If yes, please include dates:							
Vaccinations	MMR	NO		YES		Date	
	Meningitis C	NO		YES		Date	
	Tuberculosis	NO		YES		Date	
	DTP & Polio	NO		YES		Date	

Please continue on other side of page

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Have you ever suffered from the following?					
Anxiety	NO		YES	Date	
Depression	NO		YES	Date	
OCD	NO		YES	Date	
Bipolar Disorder	NO		YES	Date	
Do you suffer from any other mental health issues (if yes give details)					

Are you a carer?	Y/N	*Details:*
Do you have a carer?	Y/N	*Details:*
Do you hold a Living Will?	Y/N	
Are you registered disabled?	Y/N	

Have you ever suffered from:

	Y/N	Date Diagnosed	
Epilepsy			
High Blood Pressure			
Heart Attack/Stroke			
Blindness/Glaucoma			
Diabetes			
Asthma			
COPD			
Eczema/Hay Fever			
Cancer			
Have you had a Cervical Smear		Date:	Result
Have you been pregnant		Date	

Ethnic Origin (Please circle and specify background if mixed background or other)

White:	British	Irish	Other	
Black :	Caribbean	African	Other	
Asian :	Indian	Pakastani	Chinese	Other
Mixed :	White+ Black Caribean	White + Black African	White + Asian	Other

Contacting You:

I consent to being contacted via Email and/or Text Message with appointment reminders or routine clinic invitations (please tick) ☐

I decline to being contacted via Email/or Text Message with appointment reminders or routine clinic invitations (please tick) ☐

Thank you for completing this form