PATIENT HEALTH QUESTIONNAIRE

Woodside Medical Practice

This document is intended to be completed by patients to provide basic health and ethnicity information. Complete all sections of this questionnaire in full. If you require it in an alternative accessible format, please make a member of the team aware.

Name:	Date of Birth:
Mobile No:	Home Telephone No:
Weight:	Height:
Email Address:	
Occupation:	

MEDICATION	
Do you have any allergies to any medication? **YES / NO**	If yes, please provide specific details of allergies:
Do you take any prescribed medication regularly? **YES / NO**	If yes, please provide details of the medication(s):
Please ensure you have a supply of at least 28 days' worth of medication from your current practice before registering with us as we are unable to prescribe any medication until you have had an initial GP appointment with one of our doctors.	
In total, how many different types of medication do you take? (please circle) **1 2 3 4 5 6 7 8+**	

GENERAL INFORMATION	
Are you a smoker? **YES / EX SMOKER / NEVER SMOKED**	If yes, how many tobacco products do you smoke per day? _____ How old were you when you starting smoking? ____ Would you like to stop smoking? **YES / NO** Would you like help to quit? **YES / NO** If you used to smoke, when did you stop smoking?

If you have served in the British Armed Forces: *(NHS England are working to improve the understanding of the needs of veterans amongst NHS clinical and administrative staff. As part of this, it would be helpful if we could identify any patients who are military veterans)*	Which section of the Armed Forces did you serve in? **ARMY / ROYAL AIR FORCE / ROYAL NAVY** **ROYAL MARINES** Service No: _____ Enlistment Date: _____ / _____ / _____ Leaving Date: _____ / _____ / _____ Are you a reservist? **YES / NO** Is this your first registration with a GP since leaving the Armed Forces? **YES / NO** If yes, please provide your address before enlisting: _____ _____ _____
Female Patients Only:	When was your last smear taken? _____
Are you a carer? **YES / NO** Do you have a carer? **YES / NO** *(A carer is someone who looks after friends or relatives that need support due to frailty, a serious health condition or a disability)*	If yes, please provide details below of who you care for or who cares for you, including their relationship to you:
Is there any of the following health conditions in your immediate biological family members before the age of 65?	Heart Disease: **YES / NO** Which family member: _____ Stroke: **YES / NO** Which family member: _____ Cancer: **YES / NO** What type of cancer: _____ Which family member: _____

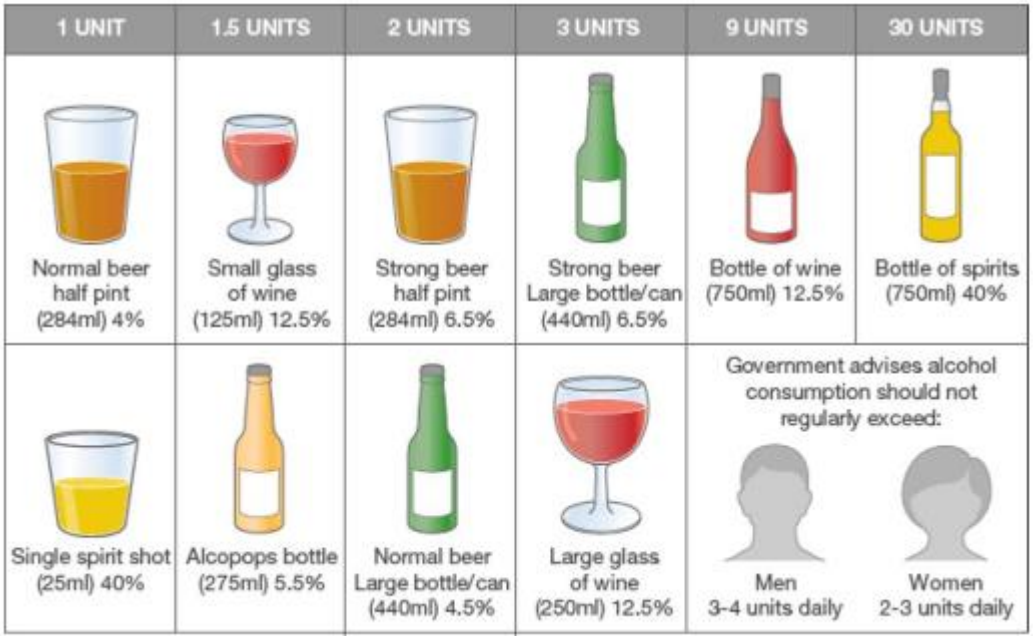
Summary Care Records are electronic records that contain information about the medication you take, allergies you suffer from and any bad reactions to medicines you may have had. Having this information stored in one place makes it easier for healthcare providers to treat you in an emergency, or when your GP Practice is closed. More information regarding Summary Care Records can be found online at www.nhscarerecords.nhs.net

Please indicate your preference for this by ticking one of the boxes:

Express **consent** for medication, allergies and adverse reactions only	☐
Express **dissent** – you do not wish to have a Summary Care Record	☐

ALCOHOL CONSUMPTION (SECTION 1)

Please complete the following questions below. Use the scoring system and if your total score is 5 or above, please complete section 2 of the Alcohol Consumption Questionnaire.



Source: ONS,NHS

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL SCORE	

ALCOHOL CONSUMPTION (SECTION 2)

Please complete the following questions below if you have scored 5 or above in Section 1 of the Alcohol Consumption .

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health professional been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL SCORE FOR THIS SECTION	
					COMBINED SCORE FOR SECTIONS 1 AND 2	

Scoring: 0-7 Lower Risk, 8-15 Increasing Risk, 16-19 Higher Risk, 20+ Possible Dependence

ACCESSIBLE INFORMATION PREFERENCES

Do you require information from the Practice to be provided in alternative formats? **YES / NO**	If yes, please provide specific details: Braille YES / NO Myself / Carer / Both Large Print YES / NO Myself / Carer / Both Audio YES / NO Myself / Carer / Both
Please indicate your preferred communication method:	*Circle all that apply* No Preference / Home Telephone / Mobile Email / Written Correspondence to Home Address Video Conference

ETHNICITY INFORMATION		
Please indicate your first/main language:		
What is your ethic group?	Prefer not to disclose	
White	British/English/Welsh/Scottish/Northern Ireland	
	Irish	
	Gypsy or Irish Traveller	
	Any other White background, please describe _____	
Mixed/Multiple Ethic Groups	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other Mixed/Multiple ethnic background, please describe _____	
Black/African/Caribbean/Black British	African	
	Caribbean	
	Any other Black/African/Caribbean background, please describe _____	
Other Ethnic Group	Arab	
	Any other ethnic group, please describe _____	