HAREWOOD MEDICAL PRACTICE

Patient Health Questionnaire – (Adults 16yrs & above)

This information is put on your health record and is helpful in assessing your health needs.

Name : **DOB / /**

Known as: **Preferred pronoun:**

Next of Kin:

Telephone Numbers

Mobile: _____ **Tick if consent not given for messages** ☐ **(Used to remind patients of appointments etc)**

Email : _____ **Home:** _____

Would you like to know about our online services? Yes ☐ **No** ☐

Circle your preferred method of communication:

Letter **Text** **Email** **Phone call**

Circle 1 Pharmacy where you would like to collect your prescriptions.

Boots (Catterick Garrison) **Boots** (Colburn) **Catterick Village Pharmacy**

What is your ethnic group? Please tick one below.

A. White

- ☐ **British**
- ☐ **Irish**
- ☐ **Any other white background**

B. Mixed

- ☐ **White & Black Caribbean**
- ☐ **White & Black African**
- ☐ **White & Asian**

C. Asian or Asian British

- ☐ **Indian**
- ☐ **Pakistani**
- ☐ **Bangladeshi**
- ☐ **Nepali**
- ☐ **Other Asian background**

D. Black or African

- ☐ **Caribbean**
- ☐ **African**
- ☐ **Other Black background**

E. Chinese or other ethnic group

- ☐ **Chinese**
- ☐ **Other ethnic group**

F. Please state your first language

_____

Height _____ **Weight** _____

Are you a Military Veteran? ☐ Yes ☐ No **Are you a Reservist? ☐ Yes ☐ No**

(Anyone who has performed military service for at least one day & drawn a day's pay is termed a veteran)

Are you a Military Dependent? ☐ Yes ☐ No

Have you had your spleen removed? ☐ Yes ☐ No Year .....

Have you ever had a pneumococcal vaccination? ☐ Yes ☐No Year .....

Do you have a learning difficulty? ☐ Yes ☐ No Year .....

Any known allergies ☐ Yes ☐ No Details .....

Do you have carer responsibilities for anyone in your household with a long-standing health problem or disability? ☐ Yes ☐ No Details .....

Can you read and write? ☐ Yes ☐ No Details .....

Are you currently receiving treatment or under Hospital care for any of the following?

☐ Heart Disease	☐ Diabetes	☐ Hypertension	☐ Thyroid Disease
☐ COPD	☐ Cancer	☐ Epilepsy	☐ Asthma
☐ Mental Health problem	☐ Eczema	☐ Contraception	☐ Heart attack

☐ Other health problems .....

Smoking information (*please tick one box*)

☐ Never smoked ☐ Ex-smoker ☐ Current smoker ☐ Electronic cigarette

Would you like help to stop smoking? ☐ Yes ☐ No

Alcohol Information (*Please circle on answer on each line that may apply to you*)

(NB – A standard alcoholic drink is half a pint, 1single measure of spirit or 1 small glass of wine)

How often do you have a drink that contains Alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many standard drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+
How often do you have 6 or more standard Drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Can we offer advice about safe levels of drinking – how much is too much? ☐ Yes ☐ No

If you are relocating from outside of ENGLAND, please could you provide us with your <u>VACCINATION HISTORY</u>.