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) | All Other Names

Title | Gender | Marital Status | Date of Birth (Day) (Month) (Year)

eg Single, Married, Separated, Widowed

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 or Student Lodging Address: House Name or No. | Road | Town | Post Code

Is this address a residential care home | Yes | No

Your House Tel. No. | Mobile Tel. No.

E-Mail 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

Name and adresss of Previous UK Doctor | Your Last Address you had when with this Doctor

If Born Outside of 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 in the UK

Surrey University Students ONLY

Name of University Department | Student ID No. | University E-Mail Address

Course Start Date | End Date

Have you had MMR booster | Yes | No | Approx date

Have you had Men C 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

Weight

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.

Has a very close relative suffered from Heart Disease or Stroke under the age of 55 years?If 'Yes',
Please tell the Doctor or Nurse to Discuss a Cholesterol Test.

Yes ☐ No ☐

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 ☐

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 ☐

A First Smear is Needed One Year After First Sexual Contact, but Not Before 25 Years of Age.

Immunisations

VACCINATIONS:	Date of Vaccination	Given by previous GP? Yes / No	Where Done GP/Clinic Country if other than UK
Influenza (flu) in the last 12 mths.			
Pneumococcal (pneumonia)			

CHILDREN ONLY (6 YEARS OR UNDER) **(please list ALL vaccinations (to include MenC and MMR)**

Vaccination	Date of Vaccination	Given by previous GP? Yes / No	Where Done GP/Clinic or Country if other than UK

Past Medical History

Do you or have any medical conditions we should be aware of ? eg Diabetes, Epilepsy,Astma 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 ?

Ethnic Category

White	British	A	☐	Asian/Asian British	Pakistani	J	☐
	Irish	B	☐		Bangladeshi	K	☐
	Other White	C	☐		Other Asian	L	☐
Mixed	White & Black Caribbean	D	☐	Black/Black British	Black Caribbean	M	☐
	White & Black African	E	☐		Black African	N	☐
	White & Asian	F	☐		Other Black	P	☐
	Other Mixed	G	☐	Other Ethnic	Chinese	R	☐
Asian/Asian British	Indian	H	☐		Other Ethnic Category	S	☐
				Not Stated	Not Stated	Z	☐

Thank you for your co-operation

Signature

Date

Some of your medical information may be held nationally.
Please tick one of these boxes if you do not wish all or some of your records to be accessed by other healthcare officials.

☐ **Please tick this box if you ONLY want information about medication, adverse reactions and allergies to be made available on the National Database**

☐ **Please tick this box if you do not wish any information to be available on the National Database (93C3)**

Once completed
Please take this form along with proof of identification (Passport or UK Driving Licence) and Utility Bill/Student ID Card to the Guildowns Surgery of your choice.

For official use ONLY

ACCEPTED

Passport ☐

Visa Date ☐

OR

UK Photo Driving License (if born in the UK) ☐

UK Birth Certificate ☐

PLUS

Utility Bills e.g. (Water, Gas, Telephone (not mobile) ☐

Student ID Card ☐

Tenancy agreement including expiry date ☐

Bank Statements are NOT ACCEPTED

Checked by | Date