



Stockwood
medical centre

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As it is likely to take several weeks for your Medical records to get to us,
it would be useful if you could please complete and return this form.

New to GP: Patient Health Questionnaire - This information is completely confidential.

Todays Date

Surname First Names

Date of Birth Place of Birth

Address

Post Code Home No.

Occupation Mobile No.

Please circle: Single/ Married/ Widowed AND Living with: Parents/ Partner/ Children/ Alone

Are you a carer for someone? Yes / No

(Do you look after someone who could not manage without you?)

If Yes, please request a **carer's pack** from reception

Name of person you care for:

D.o.B and/or address of person you care for:

Do you have a carer? Yes / No

If Yes please state who your carer is below and their relationship to you..

Name of your carer:

D.o.B and/or address of your carer:

Has any member of your family developed Heart Disease? Yes / No / Not Sure

If Yes please state their relationship to you, the age they developed it and what it was

Has any member of your family had a Stroke? Yes / No / Not Sure

If yes please state their relationship to you and the age they had it

Continued overleaf.....

Has any member of your family suffered with any of the following?

Breast Cancer
Diabetes

Huntingdon's Chorea
Blood Disorders

Spina Bifida
Asthma

If Yes please state their relationship to you, the age they developed it and what it was

Is there anything that you know you are allergic to?

Yes / No / Not Sure

If Yes please state what.

Do you smoke?

YES

How many cigarettes do you smoke a day?

How many ounces of tobacco do you smoke a day?

How many cigars do you smoke a day?

About your alcohol consumption

A standard alcoholic drink is considered to be 1 unit.

A pint of Beer, Lager or Cider or 175ml glass of Wine is 2 units. A Bottle of wine is 9 units.

A bottle of alcopop or a can of Lager or Cider is 1.5 units. A single measure of spirit is 1 unit.

1, How often do you have a drink that contains alcohol?

Never

Monthly or less

2 to 4 times a month

2 to 3 times a week

4 times a week

2, When you are drinking how many standard alcoholic drinks do you have in a typical day?

1 - 2

3 - 4

5 - 6

7 - 8

More than 10

3, How often do you have six or more standard drinks on one occasion?

Never

Less than monthly

Monthly

Weekly

Daily or almost daily

Do you exercise?

YES

What exercise do you do?

How Often do you exercise?

Do you have treatment or medication that requires regular appointments with a GP or Nurse?

This could include Depo (contraception, B12 Injections, Zoladex or Prostag etc)

NO

YES

What is it?

When is it next due?

Your Measurements

Height

Weight

Waist

Would you also please complete the patient profiling form on the next page.

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions

Choose ONE section from A to E, and then tick ONE box to indicate you background.

Name.....Date of Birth.....

A White

<input type="checkbox"/>	British
<input type="checkbox"/>	Irish
<input type="checkbox"/>	Any other white background please write in below
<input type="text"/>	

B Mixed

<input type="checkbox"/>	White and Black Caribbean
<input type="checkbox"/>	White and Black African
<input type="checkbox"/>	White and Asian
<input type="checkbox"/>	Any other mixed background please write below
<input type="text"/>	

C Asian or Asian British

<input type="checkbox"/>	Indian
<input type="checkbox"/>	Pakistani
<input type="checkbox"/>	Bangladeshi
<input type="checkbox"/>	Any other Asian background please write below
<input type="text"/>	

D Black or Black British

<input type="checkbox"/>	Caribbean
<input type="checkbox"/>	African
<input type="checkbox"/>	Any other black background please write below
<input type="text"/>	

E Chinese or other ethnic group

<input type="checkbox"/>	Chinese	
<input type="checkbox"/>	Any other please write below	
<input type="text"/>		
<input type="checkbox"/>	Declined	<input type="text"/>
<input type="text"/>		
First Language		
<input type="text"/>		