# *Patient Health Questionnaire*

Dear Patient,

Thank you for registering with The Pembridge Villas Surgery. Unfortunately it may be some time before your previous records arrive at this practice. We would therefore be grateful if you could answer the following questions. This will give us a better idea about your health, and help us to look after you. As part of your registration we will offer to check your height, weight, blood pressure and urine for a routine test.

Date of registration: ……4/5/18………………………………….

**Personal Details**

First name: ..……………John ……….……..………….………… Surname/s ……………Doe………….……………..………………………

Date of birth: ……May 12, 1966………………………. Sex: male [ x ] female [ ]

Address: ……… 1234 Apple Ave.………………………………………………………………………………………………………………………

…………………………………… ……………………………………… Zip code: ……12345………………………………………….….

Telephone number: ………(555) 555-8989………………………........Mobile Number: ………(555) 555-8989

Occupation: …………………Farmer………………….. Email ……………………john\_doe@email.com………………………

Country of origin: …………USA……………….. Ethnic origin: ………White………… (see ethnicity table)

Are you a refugee or are you seeking political asylum in the UK?: Yes[ ] No [ x ]

Next of kin (Name): ……………………Jane Smith……………………………Relationship: ………………Wife………………………

Next of kin telephone number: ………………………………(555) 555-0000…………………………………………………………

***Nominated Gp (****To be filled in by Reception. See more information on New patients leaflet) …………………………..*

**Accessible Information:**

Do you need help with mobility/hearing/speaking? (Tick all that apply) [ ] Yes [x ] no

[x ] Wheelchair [ ] Walking aid [ ] Hearing aid [ ] British sign language [ ] Makaton sign language

[ ] Lip reading [ ] Large print [ ] Braile [ ] Other. Please state: …………………………………………………

Do you require an interpreter? Yes [ ] No [x ] If yes, which language?: ……………………………………………..

**Medical History**

Do you suffer or have suffered from any of the following conditions, if yes since when?

|  |  |  |
| --- | --- | --- |
| Heart Disease | Yes [ ] No [ x ] | Since: |
| Stroke | Yes [ x ] No [ ] | Since: 5/25/2016 |
| Cancer | Yes [ ] No [ x ] | Since: |
| Diabetes | Yes [ ] No [ x ] | Since: |
| Asthma | Yes [ ] No [ x ] | Since: |
| High blood pressure | Yes [ ] No [ x ] | Since: |
| Epilepsy | Yes [ ] No [x ] | Since: |
| High Cholesterol | Yes [ ] No [ x ] | Since: |

Please list any other serious **illness, operations or accidents** you had in the past (give dates when possible).

…………………………Car Accident on 9/10/1995…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..