WEST HAMPSTEAD MEDICAL CENTRE
9 SOLENT ROAD
LONDON NW6 1TP

Patient Health Questionnaire

DATE:...

SURNAME: .... **FIRST NAME(S):...**

DATE OF BIRTH: .... **OCCUPATION:...**

TELEPHONE: (Home)............................. **(Work) ....** **(Mobile) …............................**
EMAIL ADDRESS: ....

NEXT OF KIN:.. **RELATIONSHIP TO YOU..................................**
(does not have to be a blood relative) **PHONE: ....**

If you are under 18 or filling this in onbehalf of you child please also provide the following information:

PARENT/GUARDIAN:...
ADDRESS (of parent/guardian):...

TELEPHONE:...

1. **How would you best describe your ethnic background?** (This is not necessarily the same as nationality or country of birth)**.**

☐**White British** ☐**White & Asian** ☐**Chinese** ☐**Other Asian**
☐**Irish** ☐**Indian** ☐**Carribean** ☐**Other Black**
☐**Pakistani/Brit** ☐**Bangladeshi/Brit** ☐**African** ☐**Other Mixed**
☐**Other White ....** ☐**Other** (details) **..**

2. **What is your main spoken language?**

☐**English** ☐**French** ☐**Italian** ☐**Spanish** ☐**Arabic**
☐**Greek** ☐**Bengali** ☐**Punjabi** ☐**Somali** ☐**Mandarin**
☐**Gujarati** ☐**Albanian** ☐**Urdu** ☐**Turkish** ☐**Japanese**
☐**Other** (please state)**...................................** **Do you need an interpreter?** ☐**YES** ☐**NO**

3. **Are you a carer?** (i.e; do you look after a friend or relative who is sick/disabled/has a mental health problem/any other reason?) ☐**YES** (details) **...** ☐**NO**

4. **Are you cared for?** (ie; do you have a friend/relative who helps you live your day to day life?)
☐**YES** (details) **...** ☐**NO**

PERSONAL HISTORY

5. **Have you ever suffered from any of the following?**

(If yes, please give details)

Heart Problems ☐**YES** ☐**NO** ....

Angina, Heart attack ?

☐**YES** ☐**NO** ....

Stroke ☐**YES** ☐**NO** ....

Diabetes Type 2 ☐**YES** ☐**NO** ....

Diabetes Type 1 ☐**YES** ☐**NO** ....

Asthma ☐**YES** ☐**NO** ....

Cancer ☐**YES** ☐**NO** ....

High Blood Pressure ☐**YES** ☐**NO** ....

If you have High Blood Pressure, please could you complete the separate questionnaire entitled GPPAQ.

Have you had any other illnesses or operations/surgery? ☐**YES** ☐**NO**

(If yes, please give details) ....

Are you currently taking any medications? ☐**YES** ☐**NO**

(If yes, please list names & dosages) ....

....

....

....

6. **Do you have any known allergies?** ☐**YES** ☐**NO**

(If yes, please give details) ....

7.

8. **Do you smoke?** ☐**YES** ☐**NO**

(If yes, is it) ☐ **<10/day** ☐**10-19/day** ☐**20-39/day** ☐**>40/day** ☐**more** ....

(If no, have you ever smoked)? ☐**YES** ☐**NO** (if yes, how many ***did*** you smoke)? ....

If yes, would you like help stopping?

☐**YES** ☐**NO**

Please ask at reception for information on our stop smoking clinics.

9. **Do you drink alcohol?** ☐**YES** ☐**NO**

(If yes, how many units on ***average*** do you drink a week)?

NB: 1UNIT = ½ PINT OF BEER = 1 **SMALL** GLASS WINE = 1 MEASURE SPIRITS

☐**<5/week** ☐**5-10/week** ☐**10-20/week** ☐**20-30/week** ☐**>30/week** ☐**more** ....

Please complete the short questionnaire below by either putting in your score or putting a ring around the answer that best applies to you:

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	

FAMILY HEALTH HISTORY

10. Has any close family member (including parents, siblings, aunts, uncles, grandparents) **ever suffered from any of the following?** (if yes, please give details of which relative is affected)

Heart Problems ☐ **YES** ☐ **NO** ....

Stroke ☐ **YES** ☐ **NO** ....

Diabetes ☐ **YES** ☐ **NO** ....

Asthma ☐ **YES** ☐ **NO** ....

Cancer ☐ **YES** ☐ **NO** ....

Other ☐ **YES** ☐ **NO** ....

FEMALES ONLY

11. Are you currently pregnant?

☐**YES** (If yes, when was the 1st day of your last period?) .... ☐**NO**

12. Cervical Smear History:

Date of Last Smear: .... Where Smear Taken: ....

Result ie normal or abnormal: ....

13. Any Previous Abnormal Smears? ☐**YES**

(details)...