Emis _____

WEST HAMPSTEAD MEDICAL CENTRE

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: .....

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If you are under 18 or filling this in on behalf of your 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**

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☐ **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?)
4. ☐ **YES** (details) **.....**
5. ☐ **NO**

6. **Are you cared for?** (ie; do you have a friend/relative who helps you live your day to day life?)

☐ **YES** (details)
.....
....
☐ **NO**

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PERSONAL HISTORY

7. 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**

.....

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Cancer ☐ **YES** ☐ **NO**

.....

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

.....

If you have High Blood Pressure please could you book an appointment with the Health Care Assistant

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 on the rear of this sheet)

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

(If yes, please give details)

.....

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9. 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.

10. 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	

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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	Nev	Less	Mont	Wee	Daily or	

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often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	er	than monthly	hly	kly	almostdaily	

FAMILY HEALTH HISTORY

11. **Has any close family member** (including parents, siblings, aunts, uncles, grandparents)

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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**

.....

HIV SCREENING

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12. Any new patients over 16 can have a screening test for HIV. If you would like this please book an appointment with reception to see the Health Care Assistant.

If you do not want this please tick the box:

☐ **NO**

Chlamydia

If you are sexually active and over 16 you can do a self-taken Chlamydia Test . These are available in the toilets and can be handed in at reception. Please ask at reception if you have any queries.

FEMALES ONLY

13. Are you currently pregnant?

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

14. Cervical Smear History:

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

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Result ie normal or abnormal:

.....

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

(details)**.....**

.....

Named GP

14- You will be allocated a named GP who will your point of contact within the practice. Reception will inform you who your GP is at the time of registration. You are still free to see any GP of your choice at the Practice at any time. If you wish to change your named GP in the future, simply let the reception staff know. If you have a particular preference i.e Male or Female then please inform reception at registration.

DATA SHARING

15 -There are currently three schemes whereby your medical information (held electronically within the practice) may be shared. Please indicate (by ticking the box) if you would <u>NOT</u> like your data to be shared for

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Recording Consent of New Patients for Data

the purposes of: (see http://www.westhampsteadmedicalcentre.com/Data sharing.htm)

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Sharing Initiatives in Camden		
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your • medication (last 12m) • bad reactions to medicines • allergies when you're admitted to hospital, when treating you in an emergency, or when your practice is closed.	I want to have a Summary Care Record. ***9Ndm*** ☐ I do **not** want to have a Summary Care Record. ***9Ndo*** ☐

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Care.data National In  e	Care.data aims to make increased use of information from medical records with the intention of improving healthcare via research.	I want my medical record to be part of Care.data. ☐ ***(no code)*** There are **2 levels of opt out**, you can opt out of both: I do not want my personal and confidential data to leave the Health and Social Care Information Centre ***9Nu4*** ☐ I do not want my personal ☐ confidential data to leave the GP Practice ***9Nu0***

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Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care. **PLEASE READ ATTACHED INFO**	I want to: Opt in of ☐ CIDR. Opt out ☐ of CIDR **IF YOU OPT OUT YOU MUST COMPLETE THE OPT OUT FORM > Please ask Reception for this. ADMIN- do not code opt out**

Name: ……

Date of Birth: ……

NHS Number:……

Signature:

…… .

Date: ……..

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To be completed if you have specific communication needs

Communication Support

If you struggle to complete this form, please ask a member of staff to help you.

Do you consent for this information to be shared with other health & social care organisations? Yes [ ] No [ ]

Do you need an interpreter? Yes [ ] No [ ]
Language:……

Are you visual Impaired? Yes [ ] No [ ]

Would you benefit from any of the following:

Braille [ ] Large Print [ ] Audio tape [ ]

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(please note that our system don't allow this at present, however, capturing the information will help us plan future developments)

Deafness: Yes [ ] No [ ]
Other……

If you have a difficulty communicating, which is your preferred method of communication:

Home tel number	[ ]	letter to home address	[ ]
Work tel number	[ ]	letter to temporary address	[ ]
Mobile tel number	[ ]	Fax	[ ]
Email address	[ ]	video conference*	[ ]

(*please note that our system don't allow this at present, however, capturing the information will help us plan future developments)

Do you have any other communication need we should know about? Please Describe?

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Carer Information

(i) Are you a carer for someone? (Y/N) If yes, are they registered at this practice? (Y/N)

Name of the person you care for……Their contact number…….

(ii) Do you have a carer? (Y/N) If yes, are they registered at this practice? (Y/N)

Name of the person you care for……Their contact number…….

Please ask for a Carers Pack from reception