Dr Kilpatrick & Partners, Kibworth, Market Harborough and Fleckney

PATIENT HEALTH QUESTIONNAIRE

1. Please complete this questionnaire in CAPITAL LETTERS.

2. Please attend the surgery so we can check your blood pressure, urine sample etc

We ask you for information about yourself so that you can receive proper care and treatment. This will be reviewed by our medical staff, and you may be asked to attend for a consultation with the doctor or nurse. We keep this information on computer, together with details of your treatment. Please also read the patient information and data protection statement in our practice booklet.

Surname .....

Forenames .....

Address .....

.....

Postcode .....

e-mail .....

NHS no. if known .....

Any relatives already registered with this Practice?

Next of Kin & Contact no. .....

Do you provide regular substantial care
(10 hours a week or more) to a person who is ill or disabled? Yes ☐ No ☐

Do you have a carer? Yes ☐ No ☐

Do you suffer from or have you had?:

Heart disease	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Asthma	Yes ☐	No ☐

Other chronic illness .....

(please specify) .....

Allergies & Drug Sensitivities (please specify)

.....

Personal Past Medical History

(including operations and dates - continue on a separate sheet if necessary)

Telephone No. .....

Mobile No. .....

Date and Place of Birth .....

Occupation .....

Marital Status .....

What is your ethnic group? Please tick

White
- XaQEa ☐ British
- XaJQw ☐ Irish
- XaJQx ☐ Any other White

Mixed
- XaJQy ☐ White and Black Caribbean
- XaJQz ☐ White and Black African
- XaJQ0 ☐ White and Asian
- XaJQ1 ☐ Any other Mixed

Asian or Asian British
- XaJQ2 ☐ Indian
- XaJQ3 ☐ Pakistani
- XaJQ4 ☐ Bangladeshi
- XaJQ5 ☐ Any other Asian background

Black or Black British
- XaJQ6 ☐ Caribbean
- XaJQ7 ☐ African
- XaJQ8 ☐ Any other Black background

Chinese or other
- XaJQ9 ☐ Chinese
- XaJQA ☐ Any other

Is there a family history of:

			Relationship to you (eg mother)
Heart disease	Yes ☐	No ☐	.....
Stroke	Yes ☐	No ☐	.....
High Blood Pressure	Yes ☐	No ☐	.....
Glaucoma	Yes ☐	No ☐	.....
Asthma	Yes ☐	No ☐	.....
Epilepsy	Yes ☐	No ☐	.....
Diabetes	Yes ☐	No ☐	.....
Breast cancer	Yes ☐	No ☐	.....
Bowel cancer	Yes ☐	No ☐	.....
Raised cholesterol	Yes ☐	No ☐	.....

Other chronic illness .....

(please specify) .....

First language:
- Xa6ev ☐ English

Other - please state .....

Please turn over

Do you have private medical insurance? Yes ☐ No ☐

If you are on a waiting list for an operation,
please give details of the type and the name and address of the hospital:

Smoking

Have you ever smoked? .....
Cigarettes per day .....
Pipe smoker? .....
Ex-smoker? .....
When did you give up? .....

Immunisations (tick & put date if possible)

Tetanus ☐ .....
Polio ☐ .....
Rubella ☐ .....
Others (please specify) .....
including travel vaccines .....
.....
.....

Height .....
Weight .....
What exercise do you get each week?
.....
.....
.....

Alcohol Use

XaMwb

Questions	Scoring System 0	1	2	3	4	Your Score
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Diet

Vegetarian ☐
Vegan ☐
Normal ☐
High Fibre ☐
Low fat ☐

Other (please specify) .....

Current Medication

Female Patients Only

How many pregnancies? .....
Were they normal? .....

Last Cervical Smear Result .....
Date .....

Last Mammography Result .....
Date .....

Current Contraception

For surgery use

Reg med

BP

Urine