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| **Dr S BRENNAN,** MBChB  **Dr J GRAY, BSc,** MBChB, MRCGP (2013)  **Dr E A O’LEARY,** BSc, MBChB, DRCOG, DFFP, MRCGP (2011)  **Dr K DURKAN,** MBChB, BSc (Hons), MRCGP  **Dr S TAHIR,** MBBS, DRCOG, MRCGP (2018)  **Dr S SHETTY,** MBBS, DRCOG, GPwSI Substance Misuse |  | **Bankfield Surgery**  **Huddersfield Road**  **Elland**  **West Yorkshire**  **HX5 9BA**  **Tel: 01422 374662**  [**www.bankfieldsurgery.org.uk**](http://www.bankfieldsurgery.org.uk) |

**Patient Health Questionnaire – Adult**

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| **Personal Details** | | | | | |
| Name: | | | DOB: | | Age: |
| Address: | | | | | |
| Home Number: | Mobile Number: | | | Email address: | |
| Preferred Contact Method (**please circle**): SMS Email Letter | | | | | |
| Ethnicity: | | First Language: | | | |

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| **Previous GP** |
| Dr: |
| Surgery: |

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| **Accessible Information** |
| If you need help communicating with us or with the way we communicate with you e.g braille, large font letters, sign language, please give details below: |

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| **Medical History** |
| Please list any long term conditions you have e.g. Asthma, COPD, Diabetes etc: |

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| **Medication** |
| Please list any medication you are currently taking: |

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| **Allergies** | | | | | |
| Are you allergic to any medications, substances or foods? Yes No  Please give details: | | | | | |
| **Family History** | | | | | |
| Do any members of your family suffer with any of the following conditions? **(Please tick all that apply)** | | | | | |
| **Condition** | **Yes** | **Relationship to you** | **Condition** | **Yes** | **Relationship to you** |
| Asthma |  |  | Heart Problems |  |  |
| Cancer |  |  | High Blood Pressure |  |  |
| COPD |  |  | Stroke |  |  |
| Diabetes |  |  | Other (please specify) |  |  |
| Epilepsy |  |  |

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| **Carer** | |
| Are you a carer? Yes No | If yes, what is their relationship to you? Relative Friend Neighbour |

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| **Emergency Contact Details** | |
| **Contact 1** | |
| Name: | |
| Relationship to you: | Next of Kin? Yes No |
| Address: | |
| Home Number: | Mobile Number: |
| **Contact 2** | |
| Name: | |
| Relationship to you: | Next of Kin? Yes No |
| Address: | |
| Home Number: | Mobile Number: |
| **You should notify the individual(s) you have maned above that you have provided us with their information and that we will hold this information within your electronic medical record.** | |

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| **Alcohol** | | | | | | |
| **Audit – C Questions** | **Scoring System** | | | | | **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 | 7-8 | 10+ |  |
| How often have you had 6 or more units (if female) or 8 or more units (if male), on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| **If your score is less than 5 you do not need to complete the section below.** | | | | **Total** | |  |
|  |  | | | | |  |
| **Audit Questions (if your score is 5 or more please complete the following questions).** | **Scoring System** | | | | |  |
|  | **0** | **1** | **2** | **3** | **4** | **Score** |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected of you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes but not in the last year |  | Yes during the last year |  |
| Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes but not in the last year |  | Yes during the last year |  |
|  | | | | | **Total** |  |
| If your score is 7 or more, we would like to offer you help to cut down on your alcohol intake. Would you like help with this? Yes No | | | | | | |

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| **Smoking** |
| What is your smoking status? Smoker Ex-smoker Never Smoked |
| What do you smoke? Cigarettes Cigars E-Cigarettes  Other Please specify: |
| How many/much do you smoke? |
| Would you like help to stop smoking? Yes No |
| **Depending on your responses to the questions on this form we may contact you to arrange an appointment with an appropriate clinician.** |

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| **Nominated Pharmacy** |
| Prescriptions are now sent electronically to the pharmacy of your choice. Please specify your preferred pharmacy: |

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| **Text and Email** |
| If you do not wish to receive information this way, please ask at reception to complete an Opt Out form. It is your responsibility to inform us if your contact details change. |

**For Practice Use Only**

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| Annual Review Required (Long Term Conditions)? Yes No | | Recall Added? Yes No | |
| Smoking Cessation Advice Appointment Required? Yes No | | Booked? Yes No | |
| Appointment with Pharmacist Required? Yes No | | Booked? Yes No | |
| Registered by (initials): | Completed by (initials): | | Check by (Initials): |

Updated 26/05/2022