Rolle Medical Partnership
Patient Health Questionnaire for Adults

Thank you for registering with our Practice. To enable us to give you the best possible care while we are waiting for your medical records to arrive from your previous Doctor, please would you spare a moment to complete this brief form and hand back to the Receptionist.

Identification for registration: Please see last page for a list of identification we can accept - this must be brought with you when you register with us and must be shown to the member of staff accepting your registration.

Accessible Information

If you require this information in a different format or require communication support please let us know by speaking to a member of staff or completing the relevant section on page 6.

Information about you

Title	Surname	First Names
Date of birth	Previous Surnames	
Occupation		Home Tel
Home Address ……………………………………………………… …………………………………………………………………… …………………………………………………………………… Post Code …………………………………………………………		Work Tel Mobile Email
Please tick the box to confirm that you are happy for the Surgery to send you text message reminders regarding appointments, services and practice news. ☐		

Language & Ethnicity

What is your first language?		
White	British	Irish
Black	Caribbean	African
Asian	Indian	Pakistani
Mixed	White + Black Caribbean	White + Black African
	White + Asian	Other (Please state)

Medical History

Have you ever suffered from?

Epilepsy	↑ Yes/No	Blindness/Glaucoma	↑ Yes/No
High Blood Pressure	↑ Yes/No	Diabetes	↑ Yes/No
Heart Attack/Stroke	↑ Yes/No	Depression	↑ Yes/No
Cancer	↑ Yes/No	Asthma	↑ Yes/No
Eczema/Hay Fever	↑ Yes/No	COPD	↑ Yes/No

Please list any other serious illnesses/operations/accidents/disabilities (and for women any pregnancy related problems) and the year they took place:

…… Year …………………..

…… Year …………………..

…… Year …………………..

Medication

Please attach a copy of your current repeat medication slip or list any medicines being taken and the amount:

Name	Dose
……………………………………………………………	……………………………………………………………
……………………………………………………………	……………………………………………………………
……………………………………………………………	……………………………………………………………
……………………………………………………………	……………………………………………………………
……………………………………………………………	……………………………………………………………

Which Chemist would you like us to send your prescription to? (Please tick)

Clarepharm		Pines	
Boots		Rowlands	
Jhoots		Tesco	
Lewis		Lloyds Budleigh (Large)	
Withycombe		Lloyds Budleigh (Small)	
Whites		Other (Please state)	

Previous Doctor

Name and address of previous GP ……………………………………………………………………………………………………

………

Questions

Are you registered disabled? If yes please give details.	
Do you have any allergies? If yes please give details.	
Have you ever refused treatment/screening of any kind and so, what?	
Do you hold a Living Will?	

Carers

Do you have a Carer? If Yes please provide details.	
Are you a Carer? If yes please provide details.	

Height & Weight

What is your height?		What is your weight?	

Family History

Please state any serious illness, in particular heart disease, strokes, high blood pressure, diabetes or any inherited disease and which family member it relates to.			
High Blood Pressure		Diabetes	
Heart Disease		Stroke	
Other		Other	

Next of Kin

Name:	Tel Number:
Address: ……… …… ……	

Alcohol

Because alcohol use can affect your health and can interfere with certain medication and treatment, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Please place an X in one box that best describes your answer to each question.

Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 – 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. 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
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. 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
8. How often during the last year have you been unable to remember what happened the night before because of your dinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

Smoking Status

Do you Smoke? If yes what do you smoke?	Yes/No
If no have you ever smoked?	Yes/No
If you do currently smoke, how many cigarettes or ounces of tobacco to you smoke per week?	
Would you like advice on giving up smoking	Yes/No

Identification Required to register with our practice

A combination of the following can be accepted as identification (it is preferable that one item of photo ID is seen, along with one document containing the patient's address):

Staff: please tick and initial the identification you have been shown:

- birth certificate ☐
- marriage certificate ☐
- medical card ☐
- driving licence ☐
- passport ☐
- local authority rent card ☐
- paid utility bills ☐
- bank/building society cards/statements ☐
- National Insurance number card ☐
- payslip ☐
- letter from Benefits Agency/benefit book/signing on card ☐
- papers from the home office ☐
- P45. ☐

Signature: ………………………………………………………………… Date:……………………….

Accessible Information

If you require information in a different format or communication support, please indicate by ticking a box below your preferred format and we will add this to your records.

Telephone		**British Sign Language**	
Letter		**Makaton**	
Email		**Braille Uncontracted (Grade1)**	
Short Message Service Text Message		**Braille Contracted (Grade 2)**	
Via Carer		**Written in Large font**	
Loud Verbal Communication		**Written in Large font 20 point**	
Text Relay		**Written in Large font 24 point**	
Via Telephone Interpreting Line		**Written in Large font 28 point**	

ONLINE SERVICES

Online services are available via our practice Website or an App on your Smartphone. If you would like to sign up to this service please speak to a member of the reception team who can set up access for you. You need to register for this service in person at the practice for this service as your ID will need to be checked. Benefits to this service include:

- Booking and cancelling appointments with GPs
- Ordering repeat medication
- Viewing your medical records and test results
- Updating your personal details
- Complete questionnaires and ask questions

You can access online services through our website www.rollemedicalpartnership.co.uk or via an app on your smartphone (search for SystmOnline by TPP medical).

Patient Consent to Data Sharing

We recognise the importance of protecting personal and confidential information in all that we do, and we will take care to meet our legal duties, as the law determines how organisations can use the personal information that we collect.

To support our statutory obligations, we must inform you of who we will share information with and allow you to determine whether or not you wish us to share the information that we have recorded about you within your patient record. For further information on who we share with and what steps we take to protect the information we hold, please see our Fair Processing Notice or Privacy Notice available on our website www.rollemedicalpartnership.co.uk or at the Practice.

If you wish to withdraw your consent from the NHS Digital National Data Extraction please visit the 'Your Data Matters' website www.nhs.uk/your-nhs-data-matters. This is the government data extraction that is used to help design health services of the future and to guide future research. Please note we are not able to change your consent preferences for this in the Practice.

I give my consent to my records being shared for the following purposes:-

Please tick against each data set identifying if you wish or do not wish to share data

Record Sharing Initiative	I hereby give consent for my information to be shared.	I do not consent for my information to be shared.
Summary Care Record (used in health care settings to see your basic health information, medication, major conditions and allergies)		
Local Shared Care Record (local providers only eg other GP Practices)		
Consent for this organisation to view data that is recorded at other care services (other GP Practice you may attend)		

Full Name: ………………………………………………………………………… DOB: …………………………………….

Signature: …………………………………………………………………………

Please note you can amend your consent preferences at any time.