|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PATIENT HEALTH QUESTIONNAIRE | | | | |
| All questions contained in this questionnaire are strictly confidential and will become part of your medical record. | | | | |
| Full Name: |  | 🞎 Male  🞎 Female | Date of Birth: |  |
| Marital status: 🞎 Single 🞎 Co-habiting 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed  🞎 Civil Partnership | | | | |
| First language: Email Address: | | | | |

|  |  |  |
| --- | --- | --- |
| White | British |  |
| White | Irish |  |
| White | Any other white background |  |
| Mixed | White and black Caribbean |  |
| Mixed | White and black African |  |
| Mixed | White and Asian |  |
| Mixed | Any other mixed background |  |
| Asian or Asian British | Indian |  |
| Asian or Asian British | Pakistani |  |
| Asian or Asian British | Bangladeshi |  |
| Asian or Asian British | Any other Asian background |  |
| Black or Black British | Caribbean |  |
| Black or Black British | African |  |
| Black or Black British | Any other black background |  |
| Other ethnic groups | Chinese |  |
| Other ethnic groups | Other white European |  |

**Have you been registered with this practice before?  Yes  No**

**Carers Information**

Are you a carer?  Name and relationship of the person you care for?

…………………………………………………………………………………………………………………..

Are you cared for?  Name of carer and the relationship (if any)?

…………………………………………………………………………………………………………………...

**Smoking Status**:  Never smoked  Ex-smoker  Current Smoker

How many a day do you smoke? …………………………………..