Region | Practice number | GP surname | GP initial | Postcode | Patient number

SPHERE - GP

Female ☐ Male ☐ Date of Birth ☐☐ Day ☐☐ Month ☐☐☐☐ Year Postcode ☐☐☐☐

We would like to know about your general health. For ALL questions, please fill in the appropriate response circle. Please fill in the circles like this: ●

For example:

	some of the time or never	*a good part of the time*	*most of the time*
Are you troubled by nightmares?	○	●	○

Over the **past few weeks** have you been troubled by:

	never or some of the time	a good part of the time	most of the time
1. Headaches?	○	○	○
2. Feeling irritable or cranky?	○	○	○
3. Poor memory?	○	○	○
4. Pains in your arms or legs?	○	○	○
5. Feeling nervous or tense?	○	○	○
6. Muscle pain after activity?	○	○	○
7. Waking up tired?	○	○	○
8. Rapidly changing moods?	○	○	○
9. Fainting spells?	○	○	○
10. Nausea?	○	○	○
11. Arms or legs feeling heavy?	○	○	○
12. Feeling unhappy and depressed?	○	○	○
13. Gas or bloating?	○	○	○
14. Fevers?	○	○	○
15. Back Pain?	○	○	○
16. Needing to sleep longer?	○	○	○
17. Prolonged tiredness after activity?	○	○	○
18. Sore throats?	○	○	○
19. Numb or tingling sensations?	○	○	○
20. Feeling constantly under strain?	○	○	○
21. Joint pain?	○	○	○
22. Weak muscles?	○	○	○
23. Feeling frustrated?	○	○	○
24. Diarrhoea or constipation?	○	○	○
25. Poor sleep?	○	○	○
26. Getting annoyed easily?	○	○	○
27. Everything getting on top of you?	○	○	○
28. Dizziness?	○	○	○
29. Feeling tired after rest or relaxation?	○	○	○
30. Poor concentration?	○	○	○
31. Tired muscles after activity?	○	○	○
32. Feeling lost for words?	○	○	○
33. Losing confidence?	○	○	○
34. Being unable to overcome difficulties?	○	○	○

Have you recently:	No	Yes
35. thought that you should cut down on alcohol or addictive drugs?	○	○
36. had a friend, relative or doctor suggest that you should cut down on alcohol or addictive drugs?	○	○

Reason for seeing your doctor today: _____

Today's date ☐☐ Day ☐☐ Month ☐☐☐☐ Year