

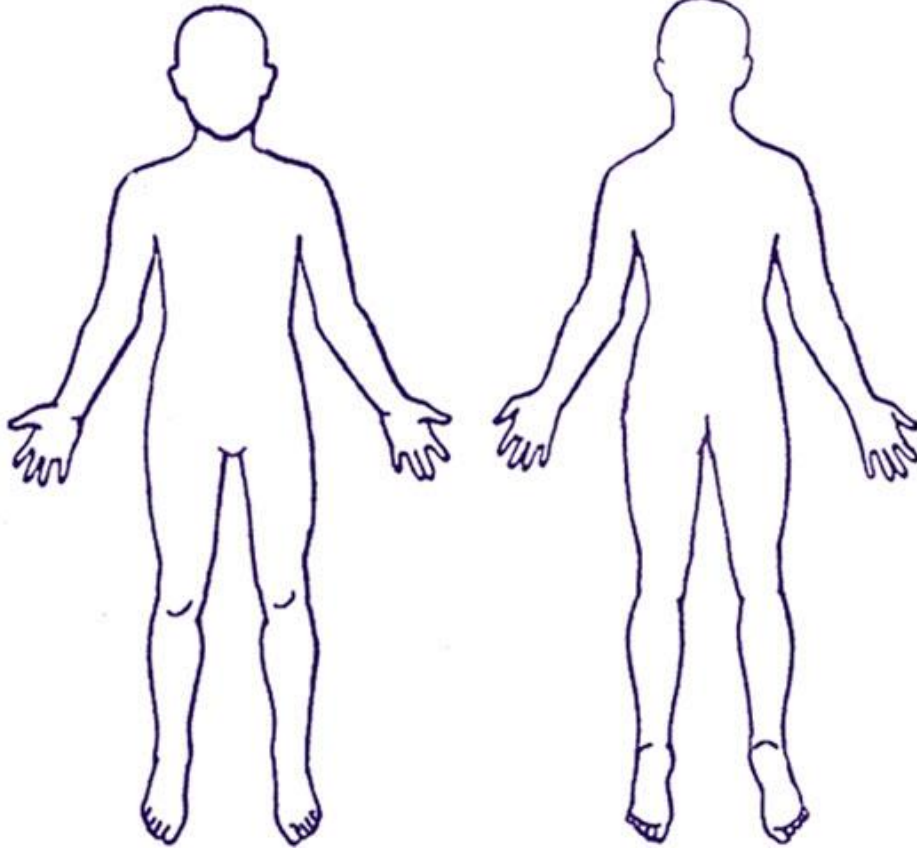
English	Amharic / አንግሊዝኛ
<p>New Patient Questionnaire for newly arrived migrants in the UK</p> <p>Everyone has a right to register with a GP. You do not need proof of address, immigration status, ID or an NHS number to register with a GP.</p> <p>This questionnaire is to collect information about your health so that the health professionals at your GP practice can understand what support, treatment and specialist services you may need in accordance with the confidentiality and data sharing policies of the National Health Service.</p> <p>Your GP will not disclose any information you provide for purposes other than your direct care unless: you have consented (e.g. to support medical research); or they are required to do so by law (e.g. to protect other people from serious harm); or because there is an overriding public interest (e.g. you are suffering from a communicable disease). Further information about how your GP will use your information is available from your GP practice.</p> <p>Return your answers to your GP practice.</p>	<p>በቅርቡ ወደ UK ለደረሱት አዳዲስ ስደተኞች አዲስ የታካሚ መጠይቅ</p> <p>እያንዳንዱ ሰው በ GP ላይ የመመዘገብ መብት አለው አድራሻን፣ የስደተኝነት ሁኔታን፣ መታወቂያን ወይም በGP ላይ የተመዘገቡበትን የ NHS ቁጥር ማረጋገጫ ማቅረብ አያስፈልግዎትም።</p> <p>ይህ መጠይቅ የሚደረገው የጤና ባለሙያዎች በእርስዎ GP ተግባር አማካይነት ምን ዓይነት እርዳታ፣ ህክምና ሊያስፈልግዎ እንደሚችል ለመረዳት እና ሚስጥራዊነቱን በጠበቀ መልኩ እና የብሔራዊ የጤና አገልግሎት የመረጃ ማጋራት መምሪያዎችን መሰረት ባደረገ መልኩ ምን ዓይነት የስፔሻሊስት አገልግሎቶች እንደሚያስፈልጉዎት ለመረዳት እንዲችሉ ስለጤናዎ መረጃን ለመሰብሰብ ነው።</p> <p>የእርስዎ GP እርስዎ በቀጥታ ለእርስዎ ከሚሰጠው እንክብካቤ ዓላማዎች ውጪ ማንኛውንም የእርስዎን መረጃዎች አያሳይም፤ ይህ ሊሆን የሚችለው ግን፡ እርስዎን (ለምሳሌ፡- የህክምና ምርመራን ለመርዳት) ተስማምተው ካልሆነ፤ ወይም እነርሱ በሕግ አስገዳጅነት እንዲያደርጉ ተደርገው ካልሆነ (ለምሳሌ፡- ከከፋ ጉዳት ሌሎችን ሰዎች ለመከላከል)፤ ወይም የሕዝብ ፍላጎትን ጨፍልቆ ከሆነ (ለምሳሌ፡- እርስዎን ተላላፊ በሆነ በሽታ እየተሰቃዩ ከሆነ) በስተቀር አይገልጽም። የእርስዎ GP የእርስዎን መረጃ እንዴት እንደሚጠቀም የበለጠ መረጃ ለማግኘት በእርስዎ የ GP ተግባር ላይ ያገኙታል።</p> <p>የእርስዎን መልሶችን በእርስዎ የ GP ተግባር ላይ ይመልሱት።</p>
<p>Section one: Personal details</p>	<p>ክፍል አንድ፡ የግል ዝርዝር መረጃ</p>
<p>Full name:</p>	<p>ሙሉ ስም፡-</p>
<p>Address:</p>	<p>አድራሻ፡-</p>
<p>Telephone number:</p>	<p>የስልክ ቁጥር፡-</p>
<p>Email address:</p>	<p>የኢሜይል አድራሻ፡-</p>

<p>Please complete all questions and tick all the answers that apply to you.</p>	<p>እባክዎን ሁሉንም ጥያቄዎችን ያማሉ እና ለእርስዎ ተገቢ ነው ብለው የሚያስቡትን መልሶችን ሁሉ ላይ ምልክት ያድርጉበት።</p>
<p>1.1 Date questionnaire completed:</p>	<p>1.1 መጠይቅ የሚያልቅበት ቀን፡-</p>
<p>1.2 Which of the following best describes you?</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Prefer not to say</p>	<p>1.2 ከሚከተሉት ውስጥ እርስዎን ጥሩ አድርጎ የሚገልጽዎት የቱ ነው?</p> <p><input type="checkbox"/> ወንድ</p> <p><input type="checkbox"/> ሴት</p> <p><input type="checkbox"/> ሌላ</p> <p><input type="checkbox"/> መግለጽ አልፈልግም</p>
<p>1.3 Is this the same gender you were given at birth?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Prefer not to say</p>	<p>1.3 ይህ በተወለዱ ጊዜ ከነበርዎት ጾታ ጋር ተመሳሳይ ነው?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p> <p><input type="checkbox"/> መግለጽ አልፈልግም</p>
<p>1.4 Date of birth: Date _____ Month _____ Year _____</p>	<p>1.4 የትውልድ ቀን፡- ቀን _____ ወር _____ ዓመት _____</p>
<p>1.5 Religion:</p> <p><input type="checkbox"/> Buddhist</p> <p><input type="checkbox"/> Christian</p> <p><input type="checkbox"/> Hindu</p> <p><input type="checkbox"/> Jewish</p> <p><input type="checkbox"/> Muslim</p> <p><input type="checkbox"/> Sikh</p> <p><input type="checkbox"/> Other religion</p> <p><input type="checkbox"/> No religion</p>	<p>1.5 ሃይማኖት፡-</p> <p><input type="checkbox"/> የቡድሃ ሃይማኖት ተከታይ</p> <p><input type="checkbox"/> ክርስቲያን</p> <p><input type="checkbox"/> ህንዳ</p> <p><input type="checkbox"/> ይሁድነት</p> <p><input type="checkbox"/> ሙስልም</p> <p><input type="checkbox"/> ሲካህ</p> <p><input type="checkbox"/> ሌላ ሃይማኖት</p> <p><input type="checkbox"/> ሃይማኖት የለሽ</p>
<p>1.6 Marital status:</p> <p><input type="checkbox"/> Married/civil partner</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> None of the above</p>	<p>1.6 የጋብቻ ሁኔታ፡-</p> <p><input type="checkbox"/> ያገባ/የትዳር አጋር ያለው</p> <p><input type="checkbox"/> የተፋታ</p> <p><input type="checkbox"/> ባል የሞተበት</p> <p><input type="checkbox"/> ከዚህ በላይ ያለው ውስጥ የለም</p>
<p>1.7 Sexual Orientation:</p> <p><input type="checkbox"/> Heterosexual (attracted to the opposite sex)</p> <p><input type="checkbox"/> Homosexual (attracted to the same sex)</p> <p><input type="checkbox"/> Bisexual (attracted to males and females)</p>	<p>1.7 የግብረሰጋ ግንኙነት ዝንባሌው፡-</p> <p><input type="checkbox"/> የተቃራኒ ጾታ ጋብቻ (ወደ ተቃራኒ ጾታ መሳብ)</p> <p><input type="checkbox"/> የወንድ ለወንድ እና የሴት ለሴት ጋብቻ (ወደ ተመሳሳይ ጾታ መሳብ)</p> <p><input type="checkbox"/> የሁለቱም ጾታ ጋብቻ (በወንዶች እና በሴቶች መሳብ)</p> <p><input type="checkbox"/> መግለጽ አልፈልግም</p>

<input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other	<input type="checkbox"/> ሌላ
<p>1.8 Main spoken language:</p> <input type="checkbox"/> Albanian <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> Tigrinya <input type="checkbox"/> Dari <input type="checkbox"/> Ukrainian <input type="checkbox"/> English <input type="checkbox"/> Urdu <input type="checkbox"/> Persian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<p>1.8 በዋናነት የሚነገር ቋንቋ:-</p> <input type="checkbox"/> አልባኒያኛ <input type="checkbox"/> ራሽኛ <input type="checkbox"/> ዓረብኛ <input type="checkbox"/> ትግሪኛ <input type="checkbox"/> ዳሪ <input type="checkbox"/> ዩክሬይንኛ <input type="checkbox"/> እንግሊዝኛ <input type="checkbox"/> ኡርዱ <input type="checkbox"/> ፓሪሽያኛ <input type="checkbox"/> ቪትናም <input type="checkbox"/> ሌላ
<p>1.9 Second spoken language:</p> <input type="checkbox"/> Albanian <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> Tigrinya <input type="checkbox"/> Dari <input type="checkbox"/> Ukrainian <input type="checkbox"/> English <input type="checkbox"/> Urdu <input type="checkbox"/> Persian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> None	<p>1.9 በሁለተኛ ደረጃ የሚናገሩት ቋንቋ:-</p> <input type="checkbox"/> አልባኒያኛ <input type="checkbox"/> ራሽኛ <input type="checkbox"/> ዓረብኛ <input type="checkbox"/> ትግሪኛ <input type="checkbox"/> ዳሪ <input type="checkbox"/> ዩክሬይንኛ <input type="checkbox"/> እንግሊዝኛ <input type="checkbox"/> ኡርዱ <input type="checkbox"/> ፓሪሽያኛ <input type="checkbox"/> ቪትናም <input type="checkbox"/> ሌላ <input type="checkbox"/> የለም
<p>1.10 Do you need an interpreter? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>1.10 አስተርጓሚ ይፈልጋሉ? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን</p>
<p>1.11 Would you prefer a male or a female interpreter? Please be aware that interpreter availability might mean it is not always possible to meet your preference. <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> I don't mind</p>	<p>1.11 ወንድ ወይስ ሴት አስተርጓሚ እንዲሆንልዎት ይፈልጋሉ? እባክዎን አስተርጓሚ አለ ማለት ሁል ጊዜ የአርስዎን ምርጫ ማቅረብ ይችላሉ ማለት አለመሆኑን ይረዱልን። <input type="checkbox"/> ወንድ <input type="checkbox"/> ሴት <input type="checkbox"/> ከሁለቱ አንዱ ሊሆኑ ይችላሉ</p>
<p>1.12 Are you able to read in your own language? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I have difficulty reading</p>	<p>1.12 በራስዎ ቋንቋ ማንበብ ይችላሉ? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን <input type="checkbox"/> ለማንበብ እቸገራለሁ</p>
<p>1.13 Are you able to write in your own language? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I have difficulty writing</p>	<p>1.13 በራስዎ ቋንቋ መጻፍ ይችላሉ? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን <input type="checkbox"/> ለመጻፍ እቸገራለሁ</p>
<p>1.14 Do you need sign language support? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>1.14 የምልክት ቋንቋ ድጋፍን ይፈልጋሉ? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን</p>

<p>1.15 Please give details of your next of kin and/or someone we can contact in an emergency:</p>	<p>1.15 እባክዎን የቅርብ ዘመድዎን እና/ወይም በድንገተኛ ጊዜ ሊናገሩት የምንችለውን አንድ ሰው አድራሻ ዝርዝር ይስጡን፡-</p>				
<table border="1"> <tr> <td data-bbox="135 340 434 929"> <p>Name:</p> <p>Contact telephone number:</p> <p>Address:</p> </td> <td data-bbox="440 340 810 929"> <p><u>Next of kin</u></p> </td> </tr> </table>	<p>Name:</p> <p>Contact telephone number:</p> <p>Address:</p>	<p><u>Next of kin</u></p>	<table border="1"> <tr> <td data-bbox="817 340 1110 840"> <p>ስም፡-</p> <p>የስልክ ቁጥር መገኛ፡-</p> <p>አድራሻ፡-</p> </td> <td data-bbox="1110 340 1489 840"> <p><u>የቅርብ ዘመድ</u></p> </td> </tr> </table>	<p>ስም፡-</p> <p>የስልክ ቁጥር መገኛ፡-</p> <p>አድራሻ፡-</p>	<p><u>የቅርብ ዘመድ</u></p>
<p>Name:</p> <p>Contact telephone number:</p> <p>Address:</p>	<p><u>Next of kin</u></p>				
<p>ስም፡-</p> <p>የስልክ ቁጥር መገኛ፡-</p> <p>አድራሻ፡-</p>	<p><u>የቅርብ ዘመድ</u></p>				
<table border="1"> <tr> <td data-bbox="135 938 434 1518"> <p>Name:</p> <p>Contact telephone number:</p> <p>Address:</p> </td> <td data-bbox="440 938 810 1518"> <p>Emergency contact (if different)</p> </td> </tr> </table>	<p>Name:</p> <p>Contact telephone number:</p> <p>Address:</p>	<p>Emergency contact (if different)</p>	<table border="1"> <tr> <td data-bbox="817 848 1110 1348"> <p>ስም፡-</p> <p>የስልክ ቁጥር መገኛ፡-</p> <p>አድራሻ፡-</p> </td> <td data-bbox="1110 848 1489 1348"> <p>የአደጋ ጊዜ የማናገኘው አድራሻ (የተለየ ከሆነ)</p> </td> </tr> </table>	<p>ስም፡-</p> <p>የስልክ ቁጥር መገኛ፡-</p> <p>አድራሻ፡-</p>	<p>የአደጋ ጊዜ የማናገኘው አድራሻ (የተለየ ከሆነ)</p>
<p>Name:</p> <p>Contact telephone number:</p> <p>Address:</p>	<p>Emergency contact (if different)</p>				
<p>ስም፡-</p> <p>የስልክ ቁጥር መገኛ፡-</p> <p>አድራሻ፡-</p>	<p>የአደጋ ጊዜ የማናገኘው አድራሻ (የተለየ ከሆነ)</p>				
<p>Section two: Health questions</p>	<p>ክፍል ሁለት፡- የጤና ጥያቄዎች</p>				
<p>2.1 Are you currently feeling unwell or ill? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.1 በአሁኑ ጊዜ ደህንነት አይሰዋዎትም ወይም ታመዋል? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን</p>				
<p>2.2 Do you need an urgent help for your health problem? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.2 ለጤናዎ ችግር አስቸኳይ የሆነ ድጋፍ ያስፈልግዎታል? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን</p>				
<p>2.3 Do you currently have any of the following symptoms? Please tick all that apply <input type="checkbox"/> Weight loss</p>	<p>2.3 በአሁኑ ጊዜ ከሚከተሉት የህመም ምልክቶች ውስጥ ማንኛውም ዓይነት ይታይብዎታል? እባክዎን ተገቢ ነት ያላቸው ሁሉ ላይ ምልክት ያድርጉ</p>				

<input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Night sweats <input type="checkbox"/> Extreme tiredness <input type="checkbox"/> Breathing problems <input type="checkbox"/> Fevers <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Skin complaints or rashes <input type="checkbox"/> Blood in your urine <input type="checkbox"/> Blood in your stool <input type="checkbox"/> Headache <input type="checkbox"/> Pain <input type="checkbox"/> Low mood <input type="checkbox"/> Anxiety <input type="checkbox"/> Distressing flashbacks or nightmares <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Feeling like you can't control your thoughts or actions <input type="checkbox"/> Feeling that you want to harm yourself or give up on life <input type="checkbox"/> Other	<input type="checkbox"/> የክብደት መቀነስ <input type="checkbox"/> ሳል <input type="checkbox"/> ደም የተቀላቀለ አከታ <input type="checkbox"/> ሌሊት ማላብ <input type="checkbox"/> ከፍተኛ የሆነ የድካም ስሜት <input type="checkbox"/> የመተንፈስ ችግሮች <input type="checkbox"/> ትኩሳት <input type="checkbox"/> ተቅማጥ <input type="checkbox"/> የቆዳ መቆጣት ወይም ሽፍታዎች <input type="checkbox"/> ደም የተቀላቀለ ሽንት <input type="checkbox"/> ደም የተቀላቀለ ሰገራ <input type="checkbox"/> የራስ ምታት <input type="checkbox"/> ህመም <input type="checkbox"/> የስሜት መቀዛቀዝ <input type="checkbox"/> የጭንቀት ስሜት <input type="checkbox"/> ከጫና የሚመጣ ምላሽ ወይም የሌሊት የህልምቅዠት <input type="checkbox"/> መተኛት አለመቻል <input type="checkbox"/> ሀሳብዎን ወይም ድርጊቶችዎን ለመቆጣጠር ያለመቻል ስሜት መስማት <input type="checkbox"/> ራስዎን መጉዳት የመፈለግ ወይም በሕይወት ላይ ተስፋ የመቁረጥ ስሜት መስማት <input type="checkbox"/> ሌላ
<p>2.4 Please mark on the body image the area(s) where you are experiencing your current health problem(s)</p>	<p>2.4 እባክዎን በአሁኑ ጊዜ የጤና ችግሮች እየገጠምዎት ያለበትን ቦታ (ዎች) ላይ በሰውነት ምስል ላይ ምልክት ያድርጉ።</p>









<p>2.5 Do you have any known health problems that are ongoing?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>2.5 ረዘም ላለ ጊዜ የቆየ የታወቁ የጤና ችግሮች አሉብዎት?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p>
<p>2.6 Do you have or have you ever had any of the following? Please tick all that apply</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Blood disorder</p> <p style="padding-left: 20px;"><input type="checkbox"/> Sickle cell anaemia</p> <p style="padding-left: 20px;"><input type="checkbox"/> Thalassaemia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Dental problems</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Eye problems</p> <p><input type="checkbox"/> Heart problems</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> HIV or AIDS</p> <p><input type="checkbox"/> High blood pressure</p>	<p>2.6 ከሚከተሉት ውስጥ የትኛውንም ምልክት አልዎት ወይም ኖርብዎት ያውቃል እባክዎን ተገቢነት ያላቸው ሁሉ ላይ ምልክት ያድርጉ</p> <p><input type="checkbox"/> መግጠሚያ ህመም</p> <p><input type="checkbox"/> አስም</p> <p><input type="checkbox"/> የደም መዛባት</p> <p style="padding-left: 20px;"><input type="checkbox"/> የደም ማነስ</p> <p style="padding-left: 20px;"><input type="checkbox"/> የቀይ የደም ሴል ማነስ ችግር</p> <p><input type="checkbox"/> ካንሰር</p> <p><input type="checkbox"/> የጥርስ ችግሮች</p> <p><input type="checkbox"/> የስኳር ህመም</p> <p><input type="checkbox"/> የሚጥል በሽታ</p> <p><input type="checkbox"/> የዓይን ችግሮች</p> <p><input type="checkbox"/> የልብ ችግሮች</p> <p><input type="checkbox"/> የሄፕታይቲስ ቢ</p> <p><input type="checkbox"/> ሄፕታይቲስ ሲ</p>

<input type="checkbox"/> Kidney problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Long-term lung problem/breathing difficulties <input type="checkbox"/> Mental health problems <ul style="list-style-type: none"> <input type="checkbox"/> Low mood/depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Post-traumatic stress disorder (PTSD) <input type="checkbox"/> Previously self-harmed <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Other <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Skin disease <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Other	<input type="checkbox"/> የኤችአይቭ ወይም ኤድስ <input type="checkbox"/> ከፍተኛ የደም ግፊት <input type="checkbox"/> የኩላሊት ችግሮች <input type="checkbox"/> የጉበት ችግሮች <input type="checkbox"/> ረዘም ላለ ጊዜ የቆየ የሳንብ ችግር/የአተነፋፊ ችግሮች <input type="checkbox"/> የአእምሮ ጤና ችግሮች <ul style="list-style-type: none"> <input type="checkbox"/> የስሜት መቀዛቀዝ/ጭንቀት <input type="checkbox"/> የጭንቀት ስሜት <input type="checkbox"/> ድኅረ- የስቀቀን ጭንቀት መዛባት (PTSD) <input type="checkbox"/> ቀደም ብሎ ያለ ራስን መጉዳት <input type="checkbox"/> ራስን ለማጥፋት የተደረገ ሙከራ <input type="checkbox"/> ሌላ <input type="checkbox"/> አስተዋጥሮሲስ (የአጥንት በሽታ) <input type="checkbox"/> የቆዳ በሽታ <input type="checkbox"/> በደም ግፊት ራስን መሳት <input type="checkbox"/> የታይቦይድ በሽታ <input type="checkbox"/> የሳንባ ነቀርሳ (ቲቢ) <input type="checkbox"/> ሌላ
<p>2.7 Have you ever had any operations / surgery?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2.7 ከዚህ ቀደም ማንኛውም የቀዶ ጥገና ህክምና /ስርጀሪ አድርገው ያውቃሉ?</p> <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
<p>2.8 If you have had an operation / surgery, how long ago was this?</p> <input type="checkbox"/> In the last 12 months <input type="checkbox"/> 1 – 3 years ago <input type="checkbox"/> Over 3 years ago	<p>2.8 የቀዶ ጥገና ህክምና/ስርጀሪ አድርገው የሚያውቁ ከሆነ፣ ካደረጉ ምን ያህል ጊዜ ሆኖታል?</p> <input type="checkbox"/> ባለፉት 12 ወራት ውስጥ <input type="checkbox"/> ከ1--3 ዓመት <input type="checkbox"/> ከ 3 ዓመት በላይ
<p>2.9 Do you have any physical injuries from war, conflict or torture?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2.9 ከጦርነት፣ ከግጭት ወይም ከግርፋት የተነሳ ማንኛውም አካላዊ ጉዳት አለብዎት?</p> <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
<p>2.10 Do you have any mental health problems? These could be from war, conflict, torture or being forced to flee your country?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2.10 ማንኛውም የአእምሮ ጤና ችግሮች አለብዎት? ይህ ከጦርነት፣ ከግጭት፣ ታስሮ ከመሰቃየት ወይም አገርዎን ለቀው እንዲሰደዱ ከማስገደድ የተነሳ ሊሆን ይችላሉ?</p> <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
<p>2.11 Some medical problems can run in families. Has a member of your immediate family (father, mother, siblings, and grandparents) had or suffered from</p>	<p>2.11 አንዳንድ የጤና ችግሮች በቤተሰቦች መካከል ይገኛል። የእርስዎን የቅርብ የቤተሰብ አባላት (አባት፣ እናት፣ ወንድሞች እና እህቶች፣ እንዲሁም አያቶች) ከሚከተሉት መካከል የትኛው በሽታ ኖርዎት ወይም ተሰቃይተውበት</p>

<p>any of the following? Please tick all that apply</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Depression/Mental health illness</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Other</p>	<p>ያውቃሉ? እባክዎን ተገቢነት ያላቸው ሁሉ ላይ ምልክት ያድርጉ</p> <p><input type="checkbox"/> ካንሰር</p> <p><input type="checkbox"/> የስኳር ህመም</p> <p><input type="checkbox"/> ጭንቀት/የአእምሮ ጤና መታወክ ህመም</p> <p><input type="checkbox"/> የልብ ህመም</p> <p><input type="checkbox"/> ከፍተኛ የደም ግፊት</p> <p><input type="checkbox"/> በደም ግፊት ራስን መሳት</p> <p><input type="checkbox"/> ሌላ</p>								
<p>2.12 Are you on any prescribed medicines?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes –<i>please list your prescribed medicines and doses in the box below</i></p> <p>Please bring any prescriptions or medications to your appointment</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">Name</th> <th style="width: 40%;">Dose</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	Name	Dose			<p>2.12 በሃክም የታዘዘ ማንኛውንም መድኃኒቶችን እየወሰዱ ነው?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን - እባክዎን ይዘርዝሩ የታዘዘልዎትን መድኃኒቶች እና መጠናቸው ከዚህ በታች ባለው ሳፕን ውስጥ ይግለጹ</p> <p>እባክዎን ማንኛውንም የሃኪም ትእዛዝ ወይም መድኃኒቶችን ለቀጠሮዎ ሲመጥይ ይዘው ይምጡ</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">ስም</th> <th style="width: 40%;">መጠን</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	ስም	መጠን		
Name	Dose								
ስም	መጠን								
<p>2.13 Are you worried about running out of any these medicines in the next few weeks?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>2.13 በቀጣይ ጥቅት ሳምንታት ውስጥ እነዚህን መድኃኒቶች ያልቆብኛ ብለው አሳስብዎት ያውቃል</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p>								
<p>2.14 Do you take any medicines that have not been prescribed by a health professional e.g medicines you have bought at a pharmacy/shop/on the internet or had delivered from overseas?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes –<i>please list medicines and doses in the box below</i></p> <p>Please bring any medications to your appointment</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">Name</th> <th style="width: 40%;">Dose</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	Name	Dose			<p>2.14 በጤና ባለሙያ ያልታዘዘልዎትን ማንኛውንም የሚወስዱት መድኃኒቶች ለምሳሌ:- ከመድኃኒት መደብር/ሱቅ/ከኢንተርኔት ቀጥታ መስመር የገዙት ወይም ከውጪ አገር የሚመጣልዎት መድኃኒቶች አሉ?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን - እባክዎን መድኃኒቶቹን እና መጠናቸውን ከዚህ በታች ባለው ሳፕን ውስጥ ይዘርዝሯቸው</p> <p>እባክዎን ማንኛውንም መድኃኒቶችን ለቀጠሮዎ ሲመጡ ይዘው ይምጡ</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 60%;">ስም</th> <th style="width: 40%;">መጠን</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	ስም	መጠን		
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ስም	መጠን								

2.15	Are you allergic to any medicines? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.15	ለማንኛውም ዓይነት መድኃኒቶች አለርጂክኖት? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
2.16	Are you allergic to anything else? (e.g. food, insect stings, latex gloves)? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.16	ለሌላ ለማንኛውም ነገር አለርጂክ አለብዎት? (ለምሳሌ:- ለምግብ፣ በነፍሳት በመነደፍ፣ ለላሰቲክ የእጅ ጓንት)? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
2.17	Do you have any physical disabilities or mobility difficulties? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.17	ማንኛውም የአካላዊ የአካል ጉዳተኛነት ወይም የመንቀሳቀስ ችግሮች አለብዎት? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
2.18	Do you have any sensory impairments? Please tick all that apply <input type="checkbox"/> No <input type="checkbox"/> Blindness <input type="checkbox"/> Partial sight loss <input type="checkbox"/> Full hearing loss <input type="checkbox"/> Partial hearing loss <input type="checkbox"/> Smell and/or taste problems	2.18	ማንኛውም የስሜት መደንዘዝ አለብዎት? እባክዎን ተገቢነት ያላቸው ሁሉ ላይ ምልክት ያድርጉ <input type="checkbox"/> አይ <input type="checkbox"/> ዕውርነት <input type="checkbox"/> በከፊል አለማየት <input type="checkbox"/> ሙሉ በሙሉ መስማት አለመቻል <input type="checkbox"/> በከፊል መስማት አለመቻል <input type="checkbox"/> ማሽተት እና/ወይም የመቅመስ ችግሮች
2.19	Do you have any learning difficulties? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.19	ማንኛውም የመማር አለመቻል ችግሮች አለብዎት? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
2.20	Is there any particular private matter you would like to discuss/raise at your next appointment with a healthcare professional? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.20	በሚቀጥለው ቀጠሮዎ ላይ ከጤና እንክብካቤ ሰጪ ባለሙያ ጋር ማንኛውም የግል የሆነ የተለየ ነገር ለመወያየት/ለማንሳት የሚፈልጉት ጉዳይ ይኖራል? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
Section three: Lifestyle questions		ክፍል ሦስት:- የአኗኗር ዘዴ ጥያቄዎች	
3.1	How often do you drink alcohol?	3.1	አልኮል የሚጠጡት በምን ያህል ጊዜ ውስጥ ነው?

<p> <input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times per month <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times per week </p> <p>There is 1 unit of alcohol in:</p> <p> 1/2 pint glass of beer</p> <p> 1 small glass of wine</p> <p> 1 single measure of spirits</p>	<p> <input type="checkbox"/> ፈጽሞ አልጠጣም <input type="checkbox"/> በየወሩ ወይም ከዚያ በታች <input type="checkbox"/> በወር ከ 2-4 ጊዜ <input type="checkbox"/> በሳምንት ከ 2-3 ጊዜ <input type="checkbox"/> በሳምንት ከ 4 ጊዜ ወይ ከዚያ በላይ </p> <p>1 መለኪያ አልኮሎል ያለው በ:-</p> <p> 1/2 መለኪያ ብርጭቆ ቢራ</p> <p> 1 ትንሽ ብርጭቆ ወይን</p> <p> 1 ነጠላ መለኪያ ስፕሪይት</p>
<p>a. How many units of alcohol do you drink in a typical day when you are drinking?</p> <p> <input type="checkbox"/> 0-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 or more </p>	<p>a. በሚጠጡበት ጊዜ በተለመደው ቀን ምን ያህል መለኪያዎች አልኮል ይጠጣሉ?</p> <p> <input type="checkbox"/> 0-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10 ወይም ከዚያ በላይ </p>
<p>b. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</p> <p> <input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily </p>	<p>b. ባለፈው ዓመት በአንድ ጊዜ ሴት ከሆኑ 6 መለኪያዎች ወይም ከዚያ በላይ፣ ወንድ ከሆኑ 8 ወይም ከዚያ በላይ ምን ያህል ጊዜ ወስደዋል?</p> <p> <input type="checkbox"/> ፈጽሞ አልጠጣም <input type="checkbox"/> ከወር በታች <input type="checkbox"/> በየወሩ <input type="checkbox"/> በየሳምንቱ <input type="checkbox"/> በየቀኑ ወይም በየቀኑ ሊባል በሚችልበት ደረጃ </p>

<p>c. Do you take any drugs that may be harmful to your health e.g. cannabis, cocaine, heroin?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> I have quit taking drugs that might be harmful</p> <p><input type="checkbox"/> Yes</p>	<p>c. ለእርስዎን ጤና ጎጂ ሊሆኑ የሚችሉ አደንዛዥ ዕጾችን ለምሳሌ፡-ካናቢስ፣ ኮኬይን፣ ሄሮይን የመሳሰሉትን ይወስዳሉ?</p> <p><input type="checkbox"/> ፈጽሞ አልጠጣም</p> <p><input type="checkbox"/> ሊጎዱ የሚችሉትን አደንዛዥ ዕጾችን በእርግጠኝነት እየወሰድኩ እገኛለሁ</p> <p><input type="checkbox"/> አዎን</p>
<p>d. Do you smoke?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> I have quit smoking</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Cigarettes</p> <p>How many per day?</p> <p>_____</p> <p>How many years have you smoked for?</p> <p>_____</p> <p><input type="checkbox"/> Tobacco</p> <p>Would you like help to stop smoking?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>d. ያጨሳሉ?</p> <p><input type="checkbox"/> ፈጽሞ አልጠጣም</p> <p><input type="checkbox"/> በደንብ አጨሳለሁ</p> <p><input type="checkbox"/> አዎን</p> <p><input type="checkbox"/> ስጋራዎችን</p> <p>በቀን ስንት? _____</p> <p>ለምን ያህል አመታት አጭሰዋል?</p> <p>_____</p> <p><input type="checkbox"/> ትንባሆ</p> <p>ማጩሰ ለማቆም እገዛ ይፈልጋሉ?</p> <p><input type="checkbox"/> አዎን</p> <p><input type="checkbox"/> አይ</p>
<p>e. Do you chew tobacco?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> I have quit chewing tobacco</p> <p><input type="checkbox"/> Yes</p>	<p>e. ትንባሆ ያኝካሉ?</p> <p><input type="checkbox"/> ፈጽሞ አልጠጣም</p> <p><input type="checkbox"/> ትንባሆ በደንብ አኝካለሁ</p> <p><input type="checkbox"/> አዎን</p>
<p>Section four: Vaccinations</p>	<p>ክፍል አራት፡- ክትባቶች</p>
<p>4.1 Have you had all the childhood vaccinations offered in your country of origin?</p> <p>If you have a record of your vaccination history please bring this to your appointment.</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I don't know</p>	<p>4.1 በተወለዱበት አገር ውስጥ ይሰጡ የነበሩትን ሁሉንም ዓይነት የልጅነት ጊዜ ክትባቶችን ወስደዋል?</p> <p>መከተብዎን የሚያሳይ የጽሑፍ ማስረጃዎች ካልዎት እባክዎን በቀጠሮዎ ቀን ይዘው ይምጡ።</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p> <p><input type="checkbox"/> አላውቅም</p>
<p>4.2 Have you been vaccinated against Tuberculosis (TB)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I don't know</p>	<p>4.2 ለሳንባ ነቀርሳ (ቲቢ)ክትባት ወስደዋል?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p> <p><input type="checkbox"/> አላውቅም</p>

<p>4.3 Have you been vaccinated against COVID-19?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p style="margin-left: 20px;"> <input type="checkbox"/> 1 dose <input type="checkbox"/> 2 doses <input type="checkbox"/> 3 doses <input type="checkbox"/> More than 3 doses </p> <p><input type="checkbox"/> I don't know</p>	<p>4.3 ለኮቪድ-19 ክትባትን ወደዋል?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p> <p style="margin-left: 20px;"> <input type="checkbox"/> 1 ዙር <input type="checkbox"/> 2 ዙር <input type="checkbox"/> 3 ዙር <input type="checkbox"/> ከ 3 ዙር በላይ </p> <p><input type="checkbox"/> አላውቅም</p>
<p>Section five: Questions for female patients only</p>	<p>ክፍል አምስት:- ለሴታ ታካሚ ብቻ የሚቀርቡ መጠይቆች</p>
<p>5.1 Are you pregnant?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> I might be pregnant</p> <p><input type="checkbox"/> Yes</p> <p>How many weeks pregnant are you? _____</p>	<p>5.1 ነፍሰ ጡር ናት?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> ነፍሰጡር ሊሆን እችላለሁ</p> <p><input type="checkbox"/> አዎን</p> <p>የስንት ሳምንታት ነፍሰጡር ናት? _____</p>
<p>5.2 Do you use contraception?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>What method do you use?</p> <p><input type="checkbox"/> Barrier contraception e.g. condoms, gel</p> <p><input type="checkbox"/> Oral contraceptive pill</p> <p><input type="checkbox"/> Copper Coil/Intrauterine device (IUD)</p> <p><input type="checkbox"/> Hormonal coil/Intrauterine System (IUS) e.g. Mirena</p> <p><input type="checkbox"/> Contraceptive injection</p> <p><input type="checkbox"/> Contraceptive implant</p> <p><input type="checkbox"/> Other</p>	<p>5.2 የወሊድ መከላከያን ይጠቀማሉ?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p> <p>ምን ዓይነት መከላከያ ዜዴ ይጠቀማሉ?</p> <p><input type="checkbox"/> መከላከያ የወሊድ መከላከያ ለምሳሌ:- ኮንዶም፣ ጄል</p> <p><input type="checkbox"/> በአፍ የሚዋጥ የወሊድ መከላከያ</p> <p><input type="checkbox"/> ኮፐር ኮይል/ኢንትራ-ሁቴሪኔ መሳሪያ (IUD)</p> <p><input type="checkbox"/> የሆርሞን ኮይል/ኢንትራ-ሁቴሪኔ ሲስተም (IUS) ለምሳሌ:-ማሬና</p> <p><input type="checkbox"/> የወሊድ መከላከያን መወጋት</p> <p><input type="checkbox"/> የወሊድ መከላከያን ማስተካል</p> <p><input type="checkbox"/> ሌላ</p>
<p>5.3 Do you urgently need any contraception?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>5.3 በአሁኑ ጊዜ በአስቸኳይ የወሊድ መከላከያ ይፈልጋሉ?</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p>
<p>5.4 Have you ever had a cervical smear or a smear test? This is a test to check the health of your cervix and help prevent cervical cancer.</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>5.4 የማዕጸን ጫፍ የካንሰር ወይም የማዕጸን ምርመራ አድርገው ያውቃሉ? ይህ የማዕጸን ጫፍ ጤንነት ለማረጋገጥ እና የማዕጸን ጫፍ ካንሰርን ለመከላከል የሚረዳ የምርመራ ዓይነት ነው።</p> <p><input type="checkbox"/> አይ</p> <p><input type="checkbox"/> አዎን</p> <p><input type="checkbox"/> የበለጠ መረጃ እንዲሰጠኝ እንድሰጠኝ እፈልጋለሁ</p>

<input type="checkbox"/> I would like to be given more information	
5.5 Have you had a hysterectomy (operation to remove your uterus and cervix)? <input type="checkbox"/> No <input type="checkbox"/> Yes	5.5 የማዕጸን ቀዶ ጥገና (የእርስዎን ማዕፈን ወይም የማዕጸን ጫፍን ቆርጦ የማስወገድ ቀዶ ጥገናን) አድርገው ያውቃሉ? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
5.6 As a female patient is there any particular private matter you would like to discuss/raise at your next appointment with a healthcare professional? <input type="checkbox"/> No <input type="checkbox"/> Yes	5.6 እንደ ሴት ታካሚ አንዳንድ ለየት ያሉ የግል የሆኑ ጉዳዮችን በሚቀጥለው ቀጠሮ በሚመጡበት ጊዜ ከጤና እንክብካቤ ሰጪ ባለሙያ ጋር ለመወያየት/ለማንሳት የሚፈልጉት ጉዳይ ይኖራል? <input type="checkbox"/> አይ <input type="checkbox"/> አዎን
If there is something that you do not feel comfortable sharing in this form and you would like to discuss it with a doctor, please call your GP and book an appointment.	በዚህ ቅጽ ላይ ለማጋራት ምቹት የማይሰጥዎት ነገሮች ካሉዎት እና ከሃኪም ጋር ለመወያየት የሚፈልጉ ከሆነ፣ እባክዎን ወደ GP ይደውሉ እና ቀጠሮ ያስይዙ።