Waimairi Rd Medical Centre
New Patient Medical Questionnaire

Please complete one form for <u>each member</u> of your family and hand back to reception

Name:_____ **DOB: __/__/__** **Occupation** _____

1. **Do you have any, or have had any of the following medical problems?, or is there a family history of the following:**

	Self	Family		Self	Family
Diabetes	☐ Yes	☐ Yes	Blood clot	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	High cholesterol	☐ Yes	☐ Yes
Heart Attack -under 60yrs (circle one) - over 60yrs	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease/ problems	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Eye problem	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

2. Do you have any **other health, disability problems or inherited conditions**? – *please list*

_____

3. Please list any **<u>regular</u> medications** that you take (including supplements)

Have you had any **operations?** ☐ No ☐ Yes *If **yes**, please list*

_____

4. Are you **allergic** to any medications? ☐ No ☐ Yes *If **yes**, please list*

_____

WAIMAIRI MEDICAL

5. Do you **smoke?** □ No □ Yes If yes, how many / day ? _____

If yes - would you like help to **quit smoking ?** □ Yes □ No

Have you ***ever*** smoked ? □ No □ Yes **If yes**, how much and for how long ? _____

or, when did you give up? _____

6. Do you drink **alcohol?** □ No □ Yes
If yes, on average, how much **per week** and which type?

_____

7. Do you have any **substance abuse** problems? □ No □ Yes

8. **Living Situation:** □Alone □With Family □Flatting □Independent unit

9. **Language/s: (if other than English)** _____

Interpreter required? : □ No □ Yes

Consent for family members to be given your medical information ?: □ No □ Yes

10. When was your last **Tetanus booster**? _____

11. Are your **childhood immunisations** up to date? □ No □ Yes □ Don't know

12. **Exercise:** Do you exercise regularly? □ No □ Yes
What exercise do you do?

_____

13. **<u>Women:</u> (*those over 20 years & have ever been sexually active*)**

When was your most recent cervical smear? _____

Have you ever had an abnormal smear? □ No □ Yes □ Don't know

14. **<u>Women</u> (*those over 40 years old*):** Have you had a mammogram? □ No □ Yes

If Yes, when was your last mammogram?_____

Signed:_____ **Date:** _____.