Indicator 20

PUKEKOHE SOUTH DOCTORS

New Patient Medical Questionnaire

Name:____ **DOB:** ____/____/____

One form per person (each family member to complete an individual form

DO YOU HAVE ANY, OR HAVE HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? OR 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 <60yr >60yr	☐ Yes ☐ Yes	☐ Yes ☐ Yes	Migraine Epilepsy	☐ Yes ☐ Yes	☐ Yes ☐ Yes
Asthma	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Other lung or respiratory disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Glaucoma	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Rheumatic Fever	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Tuberculosis (TB)	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes		☐ Yes	☐ Yes

DO YOU HAVE ANY OTHER HEALTH, DISABILITY PROBLEMS OR INHERITED CONDITIONS? – PLEASE LIST

REGULAR MEDICATIONS THAT YOU TAKE- PLEASE LIST	**HAVE YOU HAD ANY OPERATIONS? -** PLEASE LIST

ARE YOU ALLERGIC TO ANY MEDICATIONS? - PLEASE LIST	**DO YOU DRINK ALCOHOL?**	
	Never ☐ Once a month☐ 2-4 per month☐ 2-3 per week☐ 4-5 per week☐ 6-7 per week☐	How many units in a day☐ How often would you drink more than 6 drinks in a day☐ **DO YOU WANT ALCOHOL BRIEF ADVICE** ☐

DO YOU HAVE ANY SUBSTANCE ABUSE PROBLEMS? ☐	**WHAT IS YOUR OCCUPATION?**

DO YOU SMOKE? Never☐	☐ Yes	How many per day?
	Do you have your 1st cigarette within an hour of waking up ☐	
Would you like help to **quit smoking?** Our nurses can give you advice	☐ Yes ☐ No	*You will be contacted from time to time offering smoking cessation help - reply A(Accept) or D(Decline)on receipt of text*
Have you ever smoked in past?	☐ Yes	Quit Date:
DO you VAP?	☐ Yes	
<u>**Women:**</u> *(those over 20 years & sexually active)*		
When was your most recent Cervical Smear?	__/__/____	Have you ever had an abnormal smear? ☐
Have you had a Mammogram	☐ Yes date: __/__/____	☐ No

When was your last **Tetanus Booster**?		

Are your **Childhood Immunisations** up to date?	☐ Yes	☐ No	☐ Don't know

+Signed:________________________________ Date:________________________