**NEW PATIENT QUESTIONAIRE**

*We ask kindly that you complete this questionnaire as much as possible, as this will help us to identify and provide your medical needs in the best way possible.*

**Please Circle Yes/ No where applicable. Name: .**

**Do you consent for us to send you txts? YES/ NO Occupation: .**

**Medications:**

|  |  |
| --- | --- |
| Please list any Medications you are currently taking. |  |
| Do you have any allergies?  | **No** | **Yes: (please list)**  |

**Medical History**

|  |  |  |
| --- | --- | --- |
| Do you have any long term illnesses or disability (e.g. heart diease, cancer, diabetes, asthma, depression, eczema etc.)  | **No** | **Yes (please list)**  |
| Have you ever been in hospital? | **No** | **Yes (please list)**  |
| Apart from the illnesses referred to above, have you ever had any special tests (e.g gastroscopy, colonoscopy etc)  | **No** | **Yes (please list)**  |
| Have you, or your family, had any infectious diseases (e.g. Hepatitis, HIV, Tuberculosis etc).  | **No** | **Yes (please list)**  |

**Lifestyle Information**

|  |  |  |
| --- | --- | --- |
| Are you a current smoker of tobacco? | **No** | **Yes (please list how many per day)** |
| Have you ever smoked tobacco? | **No** | **Yes (please list for how long)** |
| Do you take recreational drugs or alcohol? | **No** | **Yes (please list + quantity)** |

**Family History**

|  |  |  |
| --- | --- | --- |
| Heart disease under the age of 65? | **No** | **Yes (who and approximate age of diagnosis)** |
| Diabetes | **No** | **Yes (who and approximate age of diagnosis)** |
| Stroke | **No** | **Yes (who and approximate age of diagnosis)** |
| Asthma | **No** | **Yes (who and approximate age of diagnosis)** |
| Bowel Cancer | **No** | **Yes (who and approximate age of diagnosis)** |
| Breast Cancer  | **No** | **Yes (who and approximate age of diagnosis)** |
| Other Cancers  | **No** | **Yes (who and approximate age of diagnosis)** |
| Any other inherited disease  | **No** | **Yes (who and approximate age of diagnosis)** |

**Female Patients:**

|  |  |  |
| --- | --- | --- |
| When was your last smear? | **No** | **Year:**  |
| Are you taking any contraception | **No** | **Yes (please specify)**  |
| When was your last mammogram (if over 45years)  | **Never** | **Year:**  |
| Do you give permission for us to obtain your records from the National screening register and breast screen Aotearoa?  | **No** | **Yes**  |

**Is there any other information you would like us to know?**