Whangaparaoa Medical Centre

Patient Questionnaire **Name:…………………………………………..**

- Do you have any medical condition?

◯ Heart disease or problems ◯ Diabetes ◯ Asthma

◯ Other lung or respiratory disease ◯ Thyroid problem

◯ Kidney disease or problems ◯ Liver Disease or Hepatitis

◯ Bowel Disease or problems ◯ Joint Disease or problems, arthritis

◯ Depression and/or anxiety ◯ Other mental health illnesses

◯ High Blood Pressure ◯ Angina ◯ Atrial Fibrillation

◯ Blood Clot ◯ Stroke ◯ Migraine

◯ High Cholesterol ◯ Epilepsy ◯ Breast Cancer

◯ Other Cancer ◯ Glaucoma ◯ Rheumatic Fever

◯ Eczema ◯ Hay Fever

◯ Polycystic ovary syndrome ◯ Endometriosis ◯ Other Gynaecological issues

- Does any immediate family members (father, mother, brother, sister) have any medical conditions? If other please give details.

◯ Diabetes ◯ Heart Attack below aged 55yrs for father or brother

◯ Heart Attack below aged 60yrs mother or sister

◯ Heart Attack above aged 60yrs ◯ High Blood Pressure ◯ Stroke

◯ Respiratory Disease ◯ Cancer ◯ Bowel Disease

◯ kidney Disease ◯ Other

- Have you had previous operations? If yes please give details.

◯ Orthopaedic ◯ Cardiac ◯ Kidney

◯ Gynaecological ◯ Bowel ◯ Breast

◯ facial ◯ Other

- Do you take regular medications? If so what?

◯ Yes ◯ No

- Do you have any disabilities? If you answer other please explain.

◯ visual ◯ Hearing impairment ◯ Mobility Problems

◯ Speech ◯ Other

- Are you Allergic to anything? If so please list the reaction.

◯ Yes ◯ No

- Do you smoke? If you answered yes how many per day.

◯ Yes ◯ No

- Are you an Ex-smoker? If so when did you quit? And for how many years did you smoke?

◯ Yes ◯ No

- Do you drink Alcohol? If so how much per day?

◯ Yes ◯ No

- Have you ever had any vaccinations? If so please give details and dates.

- If you are a female over 40 yrs have you ever had a mammogram? If so when?

◯ Yes ◯ No

Women who are over 20yrs and sexually active.

Have you ever had a smear test and if so when?

Have you ever had an abnormal result?

Have you ever needed to be referred for further treatment of an abnormal smear?

Signed: ________________________________ Date:_________________________

We recommend that you make a free 15 minute appointment to see the nurse. Please book with the receptionist.

Please be careful to disclose all important medical/surgical/psychiatric information. Medical records transferred from your previous GP will be held securely for reference purposes only. The notes will not be specifically reviewed unless you request us to. Or unless the Doctor feels that your medical history warrants this.

All information given will be kept confidential.