New Patient Medical Questionnaire Mt Eden 575 Doctors Ltd

Name: _____ **Preferred name:** _____ **DOB:** ___/___/_____

Gender: Male / Female / Gender diverse / Other _____ **Pronouns:** _____

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	High cholesterol	☐ Yes	☐ Yes
High blood pressure	☐ Yes	☐ Yes	Stroke or TIA	☐ Yes	☐ Yes
Heart disease or problems	☐ Yes	☐ Yes	Blood clots	☐ Yes	☐ Yes
Heart Attack or angina <60yr >60yr	☐ Yes	☐ Yes	Migraine	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes	Epilepsy	☐ Yes	☐ Yes
Other lung or respiratory disease	☐ Yes	☐ Yes	Breast cancer	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes	Other cancer	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes	Glaucoma or eye problems	☐ Yes	☐ Yes
Bowel disease or problems	☐ Yes	☐ Yes	Thyroid problems	☐ Yes	☐ Yes
Joint disease or problems, arthritis	☐ Yes	☐ Yes	Food allergies	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes	Eczema	☐ Yes	☐ Yes
Other mental health illnesses	☐ Yes	☐ Yes	Hay Fever	☐ Yes	☐ Yes

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

2. Please list any **regular medications** that you take:

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

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

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 _____
   when did you give up _____

6. Do you drink **alcohol?** ☐ No ☐ Yes If yes, on average, how much / week? _____
   and what type _____

7. Do you use recreational drugs? ☐ No ☐ Yes

8. Do you do any **physical activity?** ☐ Yes ☐ No If yes, for how long, how many days a week and what type?

9. Do you have any dietary requirements? Vegetarian / vegan / other _____

10. When was your last Tetanus booster? _____

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

Women:

12. When was your most recent cervical smear? _____ (*those over 25 years & sexually active)*
13. Have you ever had an abnormal smear? ☐ Yes ☐ No ☐ Don't know
14. Have you had a mammogram (*those over 40 years*)? ☐ No ☐ Yes If Yes, when? _____

Signed: _____ Date: _____