New Patient Questionnaire

PERSONAL DETAILS

Name		
Date of Birth	**Place of birth**	**NHI**

MEDICATIONS

Please list any medications you are taking.		
Are you allergic to any drugs?	**NO**	**YES** (Please list)

MEDICAL HISTORY

Do you have any long-term illness or disability (e.g. Heart disease, diabetes, asthma, depression, eczema etc…	**NO**	**YES** (Please list)
Have you been in hospital for any other illness? Or been treated at home for any serious illness?	**NO**	**YES** (Please list)
Have you ever seen a specialist about any other problem?	**NO**	**YES** (Please list)
Apart from any illness referred to above, have you ever had any special tests. (e.g. gastroscopy, cardiograph etc…)	**NO**	**YES** (Please list)
Have you, or you family, had any infections disease (e.g. hepatitis B, hepatitis C, HIV and or tuberculosis)?	**NO**	**YES** (Please list)

LIFESTYLE INFORMATION

Do you smoke now?	**NO**	**YES** Number per day	
Have you ever smoked	**NO**	**YES** Number per day	Gave up in
Do you drink alcohol and if so what?	**NO**	**YES** ……per day	……per week
Do you take recreational drugs and if so what? (e.g. party pills, P, E, opiates)	**NO**	**YES** (Please list)	
Do you or anyone in your family have a problem with gambling?	**NO**	**YES** (Please list)	
Daily Activity (specify type, frequency and duration).			

FAMILY HISTORY

Have any of your relatives (by blood) suffered any of the following? And who (i.e. mother, father brother, aunt, etc…and approximate age when they were diagnosed with illness.

Heart Disease under the age of 65	**NO**	**YES**

Diabetes	**NO**	**YES**
Stroke	**NO**	**YES**
Asthma	**NO**	**YES**
Bowel Cancer	**NO**	**YES**
Breast Cancer	**NO**	**YES**
Other cancers	**NO**	**YES**
Glaucoma	**NO**	**YES**
Any other inherited disease	**NO**	**YES**

WOMEN ONLY

Number of children	**NO**	**Year born**
Other pregnancies	**NO**	**YES** (please specify)
Contraception	**NO**	**YES** (please specify)
Last cervical smear (if aged 20 – 70)		
Have you ever had treatment to your cervix?	**NO**	**YES** (please specify)
Last mammogram (if aged 45 – 70)		
Have you ever had follow up or treatment after a mammogram screen?	**NO**	**YES** (please specify)

CHILDREN UNDER 16years ONLY

Immunisations up to date? If not born in NZ, do we have copy of immunisation records?	Yes/No Yes/No
Do you attend school? If Yes, which school?	Yes/No

NURSE NP CHECK

HE	**BP**
WT	**Urine**
Last Tetanus	**BMI**