newlands medical centre

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 medications? Or any significant allergies to other substances?	**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 your family, had any infectious disease (e.g. hepatitis B, hepatitis C, HIV and or tuberculosis)?	**NO**	**YES** (Please list)	
Have you had Measles, Mumps and Rubella (MMR) vaccinations?	**NO**	**YES** Date if known:	**UNSURE**

Lifestyle Information		
Do you smoke now?	**NO**	**YES** …….. per day
Have you ever smoked	**NO**	**YES** …….. per day Gave up in:
Do you vape?	**NO**	**YES** ☐ Daily ☐ Occasionally
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)
Occupation		

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** (What type? Which family member?)
Any other inherited disease	**NO**	**YES**

Women Only		
Contraception	**NO**	**YES** (please specify)
Cervical screening (smear or HPV swab) (if aged 25 – 70)	☐ Never screened ☐ Date of last screening (approx.) ……..	
Have you ever had an abnormal cervical screening result?	**NO**	**YES** (please specify)
Mammogram (if aged 45 – 70)	☐ Never screened ☐ Date of last screening (approx.) ……..	
Have you ever had follow up or treatment after a mammogram screen?	**NO**	**YES** (please specify)

Children Aged Under 16 years Only			
Immunisations up to date? If not done in NZ, do you have copy of their immunisation records?	**NO**	**YES**	**UNSURE**
	NO	**YES** If yes, please provide a copy to the Medical Centre.	
Do other people in the household smoke cigarettes?	**NO**	**YES**	

Measurements **(we can help with these)**		
Height	**Weight**	**Blood Pressure**