NEW PATIENT QUESTIONNAIRE (≥ 16yrs old)

First / Given Name: …… Last / Family Name: ……

Date Of Birth: ……. (dd) ……. (mm) ……. (yyyy) Occupation: ……..

Do you have any, or have had any of the following medical problems? NHI: ……
Or is there a family history of any of the following? (Please tick those that apply)

	SELF	FAMILY		SELF	FAMILY
Diabetes			Blood Clot		
High Blood Pressure			Stroke		
Heart Disease or Problems			High Cholesterol		
Heart Attack <60yr / >60yr			Migraine		
Asthma			Epilepsy		
Other Lung or Respiratory Disease or Problems			Breast Cancer		
Kidney Disease or Problems			Other Cancer		
Liver Disease or Hepatitis			Glaucoma		
Bowel Disease or Problems			Rheumatic Fever		
Joint Disease or Problems, Arthritis			Tuberculosis (TB)		
Depression and/or Anxiety			Eczema		
Other Mental Health Illness			Hay Fever		

2. Primary Language Spoken: …… Interpreter Needed: YES / NO (Please Circle)

3. Please list any regular medications that you take: ……

……

4. Are you allergic to any medications? YES / NO If YES – please give details:

.....

5. Have you had any hospital admissions/operations? YES / NO If YES – please give details.

……..

6. Do you smoke? YES / NO **If YES**, how many cigarettes a day? ……
If YES, would you like help to quit smoking? YES / NO
If NO, have you ever smoked? YES / NO
If you have smoked in the past, how many cigarettes a day and for how long?
……. a day for ……. months/years When did you give up? **…….**

7. Do you drink alcohol? YES / NO

If YES, on average, how much a week?..... and what type? ……

8. Do you have any substance abuse problems? YES / NO (Please circle)

9. Do you have a gambling problem? YES / NO (please circle)

10. Women over 20 years & sexually active: when was your most recent cervical smear? **…….**

Have you ever had an abnormal smear? YES / NO / Don't Know If YES, when? **…….**

11. Women over 40 years: have you had a mammogram? YES / NO If YES, when? **…….**

12. Are your childhood immunisations up to date? YES / NO / DON'T KNOW
Last Tetanus Booster? ……
Height …… cm **Weight** …… kg **BP** ……. / ……. **Waist**..... cm

13. Why did you chose to transfer to our clinic? Please **circle** all that apply:
Appointment based Cost effective Location By recommendation Able to see same GP

Patient's Signature: ..... Date: .....