North Harbour Medical Centre

New Patient Health Questionnaire

Patient Name: ____________________

Occupation: ____________________

Medical History

Do you or any close relatives (parents/siblings) have any of the following? If "YES", please indicate who - yourself and/or family.

- Diabetes ____________________
- Asthma ____________________
- Heart trouble ____________________
- Raised blood pressure ____________________
- Stroke ____________________
- Cancer ____________________
- Operations ____________________
- Glaucoma ____________________
- Thyroid trouble ____________________
- Any other inherited diseases? ____________________

____

Please list all your current medications: ____________________

____

Are you **allergic to any medications**? If yes, please list. **Y / N** ____________________

Do you have any **allergies**? ____________________

Lifestyle

Do you currently smoke? **Y / N** No. per day? ____________________

Have you ever smoked? **Y / N** No. per day? __________ When did you stop? __________

Would you like support to quit? Y / N ____________________

How much alcohol do you drink? Per day: __________ Per week: __________

What sort of regular exercise do you do? ____________________

Women

When was your last cervical smear? ____________________

Last mammogram or thermography? ____________________

Contraception used (if relevant)? ____________________

Number of pregnancies? __________ Number of children? __________

Please can you bring in the Well Child health book for all your children aged under 11 years so the nurse can update their immunisation records.

** WELCOME TO NORTH HARBOUR MEDICAL CENTRE **

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