North Harbour Medical Centre

Quality Medical Care.

New Patient Health Questionnaire

Patient Name: _____ **Occupation:** _____

❑ I authorise NHMC to contact me via text message ❑ I authorise NHMC to contact me via email (non-secure)

Email address: _____

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. Yes ❑ No ❑ _____

Do you have any **allergies?** _____

Lifestyle

Smoking status (if over 15)

- Never smoked ❑
- Ex-smoker ❑ Greater than 15 months ❑ Less than 12 months ❑
  - How many cigarettes did you smoke previously, daily? _____ And when did you stop smoking (year) _____
- Current smoker ❑ Greater than 15 months ❑ Less than 12 months ❑
  - How many cigarettes do you smoke per day? _____
- Vaping ❑ How often? _____

Would you like support to quit smoking? Yes ❑ **No** ❑

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

What sort of regular exercise do you do? _____

Women patients

When was your last cervical smear? _____

Last mammogram or thermography? _____

Contraception used (if relevant)? _____

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.