New Patient Medical Questionnaire

(Please complete all sections you are able before visiting the nurse who will help you complete the form)

Date:
Name:
Address:
Date of Birth:

Preferred Spoken Language: _____ Interpreter Required: Yes No
Do you have any special communication needs eg hearing/sight impairment? Yes No

MEDICAL HISTORY

Do you have any allergies? Yes No
If yes please give details:_____

Please tick if you have any of the following or have been diagnosed with any of these conditions:
Asthma
Epilepsy
High Blood Pressure
Congestive Heart Failure
Diabetes
Angina
Heart Attack
Stroke
COPD
Mental Health Issue
Cancer Type? _____
Other _____

FAMILY HISTORY

Asthma
Ischemic Heart Disease
Diabetes
Mental Health Issue
Cancer Type?_____

LIFESTYLE

Alcohol
Do you drink alcohol? Yes No If yes, how many drinks per week?_____
Smoking
Status: Current Smoker Ex-Smoker: How long ago?_____ Never Smoked
If current smoker how many per day?_____ # of years
Are you interested in quitting? Yes No

CURRENT SERVICES ACCESSED

WINZ	Maori Health Sevices	Public Health Services	Nurse Maude
ACC	PHO Community worker	Meals on Wheels	Physiotherapy
Home Help	Occupational Therapy	District Nursing	Housing NZ
Other _____			

Do you have an Advanced Care Plan? Yes No

Would you like to learn more about Advanced Care Plans? Yes No

WOMEN ONLY

Date of Last Cervical Smear (If applicable)_____ Normal Abnormal

Have you ever had an abnormal smear? No Yes Year? _____ Type? _____
Date of Last Mammogram (If applicable) _____

ADULT VACCINATIONS

Tetanus Date: _____ Flu Vaccination Date: _____ Shingles Vaccination_____

Childhood Immunisations (Please circle if applicable). Please supply the Well Child Book (Previously known as the plunket book)

Not Vaccinated Fully Vaccinated Partially Vaccinated

Vaccination			
6 week	Given	Not Given	Partially Given
3 months	Given	Not Given	Partially Given
5 months	Given	Not Given	Partially Given
15 months	Given	Not Given	Partially Given
4 years	Given	Not Given	Partially Given
11 years	Given	Not Given	Partially Given
MenZB	Given	Not Given	Partially Given
HPV	Given	Not Given	Partially Given

OFFICE USE ONLY:

Nurse Appointment: HT, WT, BP

Action needed?	Action needed?
Care Plus Reg/Review	Smoking Cessation
COPD clinic	Skin Cancer Clinic
Diabetes Review/clinic	B4 School Check
CVDRA	Breastscreen
Cx screening	Other_____