

New Patient Questionnaire

The relationship between Courtenay Medical and a patient is built on trust, honesty and sharing of information. We kindly ask that you complete this questionnaire as much as possible, as this will help us to identify and serve your medical needs in the best possible way.

NAME: _____

DOB: _____

Please tick No or Yes where applicable

Medications

Please list any medications you are currently taking.		
Are you allergic to any medications?	No	Yes (please list and specify type of allergy)

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 illness OR been treated at home for any serious illness?	No	Yes (please list)
Have you ever seen a specialist about a medical issue?	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 diseases? (E.g. hepatitis B, hepatitis C, HIV, tuberculosis etc.)	No	Yes (please list)

Family History

Have any of your blood relatives suffered any of the following? Please state which relative (i.e. mother, father, brother, aunt etc. and the approximate age of diagnosis of the illness) if your answer is yes.

Heart disease under the age of 65	No	Yes
Diabetes	No	Yes
Asthma	No	Yes
Stroke	No	Yes
Bowel cancer	No	Yes
Breast cancer	No	Yes
Other cancers	No	Yes

Glaucoma	No	Yes
Any other inherited disease	No	Yes

Lifestyle/Social Information

Are you currently vaping?	No	Yes	With Nicotine? No Yes Yes and I want help to quit
Are you a current smoker of tobacco?	No	Yes	If yes, do you want help to quit? Yes No
Have you ever smoked tobacco?	No	Yes	Year ceased smoking
Do you consume alcohol? <i>A standard = 330ml Beer (4% alcohol), 100ml Wine (12.5% alcohol) and 30ml spirit (42% alcohol).</i>	No	Yes	_____ Standard drinks per day/week
Do you take recreational drugs? E.g. cannabis, heroin, party pills, methamphetamine, ecstasy	No	Yes	Yes (please list)
Do you have any children?	No	Yes	What year were they born?
Please list family members whom you live with			
Are you taking or using any contraception?	No	Yes (please specify)	
Do you exercise?	No	Yes (please specify)	
Do you currently have any home supports in place? (Eg personal cares such as showering, assistance taking your medications, blister packed medication)	No	Yes (please specify)	
Do you have a current Advanced Care Plan (ACP)?	No	Yes (please ensure we have a copy on file)	
Do you have an EPOA (Enduring Power of Attorney) in place?	No	Yes	If yes, please provide details

Vaccinations

Last Tetanus Vaccination	Year or age given:	
Childhood Vaccinations	Given in NZ	Given Overseas
Other Vaccinations (eg: Travel)		

Female Patients

When was your <u>last cervical smear test in New Zealand?</u>	Year:	
Have you ever had an abnormal smear or treatment to your cervix?	No	Yes (please specify)
When was your <u>last mammogram?</u>	Year :	
Have you ever had a follow-up or treatment after a mammogram screening?	No	Yes (please specify)