peninsula medical

New Patient Questionnaire

If you prefer not to answer any questions-please leave blank
If you can't remember the exact date - please give an estimate

Personal Details

Name			
Address			
Phone-home		Phone-work	
Date of birth		Place of birth	
Marital Status	Single	Married	De facto spouse
	Separated	Divorced	Widowed
Occupation			
Medical Insurance Company			

Medical History

Have you had any operations? (include tonsils, appendix, male or female sterilisation)	Year	
Have you been in hospital for any other illness?	Year	
Have you ever seen a specialist about any other problems?	Year	
Apart from in connection with any illness referred to above, have you ever had any special test? (e.g barium meal, gastroscopy, Cardiograph)	Year	
Did you ever have any long-term illness or disability? (e.g. Raised Blood pressure, Skin Complaint, Diabetes, Asthma, Nervous Troubles)	Year Started	

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Medications

Please list any current medications	
Are you allergic to any drugs?	

Family History

Have any of your relatives (by blood) Suffered any of the following?	Heart trouble under the age of 65
	Diabetes
	Stroke
	Asthma
	Bowel Cancer
	Breast Cancer
	Glaucoma
	Thyroid trouble
	Gall bladder trouble
	Peptic ulcer
	Any Other inherited diseases?

Lifestyle

Do You smoke now?	Yes / No	Number per day
Have you ever smoked?	Yes / No	Gave up in
How much alcohol do you drink?	Per Day	Per Month
How often do you engage in regular exercise? (e.g. active gardening, brisk walking, dancing for at least 30 minutes)	Times per week	

Women

Number of Children	Year Born	
Other Pregnancies		
Form of Contraception (if relevant)		
Last cervical Smear	Month	Year

Medical Records

Have all adult members of your family joining this practice completed one of these forms?	
Would you please bring in Plunket books for all children age under 11 years old	