COUNTIES MEDICAL FAMILY HEALTH

New Patient Medical Questionnaire Adult

Please complete one form for <u>each member</u> of your family and hand back to reception

Name: _____

DOB: __/__/____ **Occupation:** _____

Medications:

Are you on any current medication?	No ☐	Yes ☐ (please list)
Do you take any non-prescribed medicines or supplements eg St John's Wort?	No ☐	Yes ☐ (please list)
Are you allergic to any medications?	No ☐	Yes ☐ (please list)

Medical History:

Do you have any long-term medical conditions or disability? (E.g, asthma, diabetes, heart disease, mental health)	No ☐	Yes ☐ (please list)
Have you been in hospital for any procedure, illness or under the care of a specialist?	No ☐	Yes ☐ (please list)
Do you have any blood relatives who have a history of health issues, infectious diseases or inherited conditions? ***Eg diabetes, hepatitis. (Please state which relative, ie mother, father, siblings, grandparents etc).***	No ☐	Yes ☐ (please list)

Lifestyle:

Are you a current smoker of tobacco?	No ☐	Yes: ☐ Number per day ____ and number of years a smoker _____ Would you like help to quit smoking Yes / No
Have you ever smoked tobacco?	No ☐	Yes: ☐ Number per day ____ and number of years a smoker _____

		Year ceased smoking _____
Do you take recreational drugs? (E.g. cannabis)	No ☐	Yes ☐ (please list)
How often do you drink alcohol	☐ Never	☐ less than monthly ☐ 2-4 times a week ☐ 2-4 times a month ☐ 4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you are drinking		☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
How often do you have six or more drinks on one occasion?	☐ Never	☐ less than monthly ☐ 2-4 times a week ☐ 2-4 times a month ☐ 4 or more times a week

Womens Health:

Have you had a cervical smear (Cx)? ***(those over 25 years & sexually active)***	☐ No ☐ Yes If Yes, when? _____
Have you had a mammogram? (M) **(*those over 45-70 years*)**	☐ No ☐ Yes If Yes, when? _____
Or do you wish to DECLINE to have them?	☐ Yes Cx M Both

Immunisations:

When was your last **Tetanus booster**? _____

Are all your **immunisations** up to date? ☐ Yes ☐ No ☐ Don't know

(if given Overseas, a copy of the immunisation records is required)

Information Sharing:

Is there anyone you consent to share your health records with? (ie phone for results, prescriptions etc)

Name: _____ ***Contact Details:*** _____

Signed:_____ Date:_____

Do you have a current legal Enduring Power of Attorney / Guardianship / Advanced Directive? ☐ Yes ☐ No

(If you have answered yes to any of the above, the clinic requests you provide a copy to be held on your records)

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this.

Please be careful to disclose all important medical/surgical/psychiatric information.