SOUTH CITY HEALTH
NEW PATIENT MEDICAL QUESTIONAIRE

Please complete one form for EACH PERSON registering and hand back to reception

Name: _____ **DOB:**_____ **NHI:** _____

1. Do you require an interpreter? ☐ Yes, please specify language _____ ☐ No
2. Do you consent to the use of AI during your consult (as a transcription method) ☐ Yes ☐ No

3. Do you have any, or have had any of the following medical problems? Or is there a family history of the following:

	Self	Family
Diabetes	☐ Yes	☐ Yes
High Blood Pressure	☐ Yes	☐ Yes
Heart Disease or Problems	☐ Yes	☐ Yes
Heart Attack ☐< 60 yr ☐> 60yr	☐ Yes	☐ Yes
Asthma	☐ Yes	☐ Yes
Kidney disease or problems	☐ Yes	☐ Yes
Other lung or respiratory disease /issues	☐ Yes	☐ Yes
Liver disease or Hepatitis	☐ Yes	☐ Yes
Bowel Disease or problems	☐ Yes	☐ Yes
Joint disease or problems	☐ Yes	☐ Yes
Depression and/or anxiety	☐ Yes	☐ Yes
Other mental health illness	☐ Yes	☐ Yes

	Self	Family
Blood Clot	☐ Yes	☐ Yes
Stroke	☐ Yes	☐ Yes
High Cholesterol	☐ Yes	☐ Yes
Migrane	☐ Yes	☐ Yes
Epilepsy	☐ Yes	☐ Yes
Other Cancer	☐ Yes	☐ Yes
Breast Cancer	☐ Yes	☐ Yes
Glaucoma	☐ Yes	☐ Yes
Rheumatic Fever	☐ Yes	☐ Yes
Tuberculosis (TB)	☐ Yes	☐ Yes
Eczema	☐ Yes	☐ Yes
Hay Fever	☐ Yes	☐ Yes

4. Do you have any other health, disability problems or inherited conditions? – Please list

5. Please list any regular medications that you take

6. Are you allergic to any medications? ☐ Yes ☐ No *If yes please list*

7. Have you had any operations? ☐ Yes ☐ No *If yes please list*

8. Do you smoke? ☐ Yes ☐ No *If yes how many / day* _____

- If Yes – Would you like help to quit smoking? ☐ Yes ☐ No
- Have you ever smoked? ☐ Yes ☐ No
- If yes, how much and for how long? _____ When did you give up? _____

9. Do you drink alcohol? ☐ Yes ☐ No
If yes, on average how much / week? _____ What type? _____

10. Do you have any substance abuse problems? ☐ Yes ☐ No

11. Women: *(Those over 25 years & have ever been sexually active)*

- When was your most recent cervical smear? _____
- Have you ever had an abnormal smear? ☐ Yes ☐ No
- Have you had a mammogram (those over 40 years)? ☐ Yes ☐ No

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

13. Are your childhood Immunisations up to date? ☐ Yes ☐ No ☐ Don't Know

Signed: _____ Date: _____