SILVERDALE MEDICAL

MILLWATER MEDICAL

NEW PATIENT QUESTIONNAIRE

Last Name:	**First Name:**	**DOB:**

Do you have any of the following (Please tick)

Diabetes	☐	Stroke	☐
Asthma	☐	Cancer of any sort	☐
Heart Trouble	☐	Operations	☐
Raised Blood Pressure	☐		

Are you aware of anyone in your family e.g. parents, grandparent with any of the above conditions? If so, please list the disease and family member below:

Please list any operations and approximate dates:

Any other significant illnesses/hospital admissions (excluding operations):

Please list all current medications:

Are you allergic to any drugs: Yes (please list) ☐ No ☐	Name of Drug: Reaction Name of Drug: Reaction:

Have you ever smoked: Yes ☐ No ☐	No. smoked per day? When did you stop?
Do you currently smoke: Yes ☐ No ☐ No. per day?	Have you ever considered giving up smoking? Yes ☐ No ☐
Would you like us to contact you regarding giving up smoking? Yes ☐ No ☐	

Do you drink alcohol? Yes ☐ No ☐	How often do you drink?
When you drink, how many drinks do you have in a typical session?	How often do you have 5 or more drinks on one occasion?

<u>Vaccination History:</u> When was your most recent Tetanus booster? Would you like an annual Flu Vaccine? Yes ☐ No ☐ For children – are all scheduled vaccines up to date? Yes ☐ No ☐	<u>Women: Please answer the following;</u> When was your last cervical smear? Last Mammogram? Where? Contraception (if relevant)

Is there any other additional information you would like us to know before we receive your medical records?

Silverdale Medical – 7 Polarity Rise, Silverdale, 0932 **Phone:** 09 427-9997 **Fax:** 09 427-8080

Doctors Name: Silverdale Medical N**ZMC:** 0000 **EDI:** silvermc **Member of ProCare PHO**